

# KRAUSS DERMATOLOGY

## Patient Registration Form

**Please bring insurance card and photo I.D. to your appointment.**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

E-mail \_\_\_\_\_ I do not have e-mail

May we send you an e-mail appointment reminder? Yes  No

Do you want to be on our e-mail list for new office developments, newsletters etc? Yes  No

**Please give us the following information to facilitate our communication with your primary care M.D.:**

Primary Care Name (first and last) \_\_\_\_\_

Did your doctor give you an insurance referral for our office? Yes  No

Primary Care Phone # \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Cardholder Name \_\_\_\_\_ Cardholder D.O.B. \_\_\_/\_\_\_/\_\_\_ Relationship \_\_\_\_\_

**Please give us the following information to facilitate getting your prescriptions filled:**

Pharmacy Name \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_

I have been able to review the Krauss Dermatology Notice of Privacy Practices (available in our office or on our web site). This notice provides information about how Krauss Dermatology may use and disclose my protected health information, what its legal duties are regarding my protected health information, and what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at Krauss Dermatology for clarification.

Yes  Not Yet

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## KRAUSS DERMATOLOGY

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Please read and darken the circle for the appropriate response regarding your medical history.

<b>Female Patients Only</b>
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Currently Pregnant	<input type="radio"/> Yes	<input type="radio"/> No
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Currently Breastfeeding	<input type="radio"/> Yes	<input type="radio"/> No
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**General**

Allergies to Medications  Yes  No

Problems with Anesthesia  Yes  No

History of Cancer  Yes  No

**Constitutional**

Recent Fever or Chills  Yes  No

**Eyes**

Vision Problems  Yes  No

Eye Pain/Discomfort  Yes  No

**Neurological**

Frequent or Severe Headache  Yes  No

Numb/Tingling Hands or Feet  Yes  No

**Endocrine**

Diabetes  Yes  No

Always Tired/ Sluggish  Yes  No

**Gastrointestinal: Recent or Frequent**

Abdominal Pain  Yes  No

Nausea/Vomiting  Yes  No

Indigestion/Heartburn  Yes  No

**Have you or a family member ever had the following?**

Melanoma  Self  Family

Other Skin Cancer  Self  Family

Psoriasis  Self  Family

Eczema/Dermatitis  Self  Family

Moderate or Severe Acne  Self  Family

**Darken the circle if the answer is yes:**

Smoke?

Drink alcohol more than 4 drinks per week?

Currently work? Occupation \_\_\_\_\_

Live alone?

Wear sunscreen regularly?

Tan regularly (tanning booth or outdoors)?

**Cardiovascular**

Pacemaker  Yes  No

Chest Pain  Yes  No

Varicose Veins  Yes  No

High Blood Pressure  Yes  No

Heart Valve Problem  Yes  No

**Musculoskeletal**

Joint Replacement  Yes  No

Joint Pain/Arthritis  Yes  No

**Ear/Nose/Throat: Recent or Frequent**

Ear Infection  Yes  No

Sore Throat  Yes  No

Sinus Problems  Yes  No

**Respiratory/Allergic**

Wheezing/ Asthma  Yes  No

Frequent Cough  Yes  No

Hay Fever  Yes  No

**Hematologic/Lymphatic**

Bleeding Problems  Yes  No

Blood Clot or Stroke  Yes  No

**Psychologic**

Anxiety Disorder  Yes  No

Mood Swings  Yes  No

Depression  Yes  No

Why we ask: In dermatology, many conditions may be related to work exposures such as chemicals or intense sun. Also, recuperation from some medical or cosmetic procedures may interfere with work related tasks or public appearances. In addition, patients who live alone may need to have skin exams more frequently if we are following lesions on the back, or may need assistance with dressing changes after a procedure.

KRAUSS DERMATOLOGY

Patient Name \_\_\_\_\_

Please list any prescription medications you are regularly taking:

_____	_____
_____	_____
_____	_____

Please list any nonprescription medications you are regularly taking:

_____	_____
_____	_____

Please list any allergies to medications:

_____	_____
_____	_____

Please any environmental or skin allergies:

_____	_____
_____	_____

Please describe any medical problems you checked “yes” to on the prior medical history sheet, or any other medical issues you have that were not listed:

_____	_____
_____	_____
_____	_____
_____	_____

Please list prior surgeries with approximate date of procedure:

_____	Date _____
_____	Date _____
_____	Date _____

We appreciate your time and effort in completing these forms. The information will help us treat you safely and effectively.