PATIENT REGISTRATION FORM

Date: ____________________________

Patient Name: ____ Single ____ Married ____

Date of Birth: _____________________________ Age: __________ Sex: M F Divorced _____ Widowed ________

Home Address: ____ Town: _____________________________

State: _________________ Zip: ___________________ Social Security Number: ______________________________

Home Phone: _______________________Cell Phone: _____________________E-mail ________________________

May We Contact You Via E-Mail ____________YES _____________NO

Employer: ____ Occupation: ________________________________

Work Address: ____Work Phone: ________________________________

Emergency Contact Name: ____ Phone: ___________________________

Spouse's Name or (If child, parent(s) name): ____

Spouse's Employer (If Child, parents'): _________________________________Address: _______________________

Health Insurance (Primary): ____

Member ID#: ____Group#: ___________________________

Name of Insured: ____________________________________ Insured's Employer: ____________________________

Insured's Social Security Number: ______________________________ Insured's DOB: _________________________

Health Insurance Secondary: ____

Member ID: ____Group#: ___________________________

Name of Insured: ____ Insured's Employer: _________________________

Known Medical Problems: ____

Name of Primary Care Physician: ____________________________________ PCP Phone #:_____________________

Allergies to Drugs: ____

Medicines Being Taken: ____

Are You Pregnant? ____________________________ Planning A Pregnancy? _________________________________

Reason for today's visit: ____

How were you referred? ____

Pharmacy: __________________________________ Telephone: ____

I hereby authorize Julia B. Sabetta, M.D., to release medical information requested by any insurance company or third party payors for claims filed relating to my care. Patients who do not provide the office with their insurance card will be billed separately for any laboratory services incurred.

____

Patient Signature (If Child, Parent's)

JULIA B. SABETTA, M.D.

Dermatologic and Cosmetic Surgery

Mohs Surgery For Skin Cancer

Name: ____ Date: ______________

Telephone: (Home) _____________________________ (Work) ________________________

To provide the best care, please carefully complete all the questions. Unable to answer, leave it blank. Circle “yes” or “no”.

DO YOU OR ANY BLOOD RELATIVES HAVE (specify who)

Asthma/hay fever ………………………………………………………	yes	no
Large or numerous moles ………………………………………………	yes	no
Eczema …………………………………………………………………	yes	no
Hives ……………………………………………………………………	yes	no
Psoriasis …………………………………………………………………	yes	no
Hair or nail problems ……………………………………………………	yes	no
Skin cancer ………………………………………………………………	yes	no
Diabetes …………………………………………………………………	yes	no
Cold sores, fever blisters ………………………………………………	yes	no
Collagen vascular disease, such as lupus, schleroderma ……………	yes	no
or dermatoysitis …………………………………………………………	yes	no

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

Heart disease (rheumatic fever, pacemaker, etc.) ……………………	yes	no
Liver disease (hepatitis, etc)………………………………………………	yes	no
Lung disease (tuberculosis, etc) …………………………………………	yes	no
Duodenal or peptic ulcer …………………………………………………	yes	no
Other intestinal disease (colitis, etc) ……………………………………	yes	no
Kidney disease ……………………………………………………………	yes	no
High blood pressure ………………………………………………………	yes	no
Blood or lymph disorder …………………………………………………	yes	no
Eye disease (glaucoma, cataracts, etc) …………………………………	yes	no
Arthritis …………………………………………………………………	yes	no
Stroke ……………………………………………………………………	yes	no
Cancer ……………………………………………………………………	yes	no
Thrombophlebitis …………………………………………………………	yes	no
Tendency to easily sunburn ………………………………………………	yes	no
Pain or color change in the hands in cold weather ……………………	yes	no
Frequent infections (skin or other) ………………………………………	yes	no
Excess bleeding when cut …………………………………………………	yes	no
Poor wound healing ………………………………………………………	yes	no
Overgrown scars or keloids………………………………………………	yes	no
Skin x-ray or grenz ray treatments ………………………………………	yes	no
Growth that changed color or size, bleeds, hurts, itches………………	yes	no
Any raised growths present since birth …………………………………	yes	no
AIDS or HIV infection ……………………………………………………	yes	no

HAVE YOU EVER HAD A REACTION TO ANY OF THE FOLLOWING?

Novacaine or other local anesthetics ………………………………………… yes no

Penicillin or sulfa drugs …………………………………………………... yes no

"Mycin" or other antibiotics ……………………………………………… yes no

Topical preparations (bacitracin, neosporin, etc.)………………………………. yes no

Adhesive tape ……………………………………………………………….. yes no

Food ……………………………………………………………………… yes no

Cosmetics …………………………………………………………………... yes no

Other (please specify) ……………………………………………………… yes no

HAVE YOU EVER HAD?:

A blood transfusion ……………………………………………………. yes no

A history of IV drug use ………………………………………………….. yes no

HAVE YOU EVER USED A TANNING BED yes no

If yes how frequently ____

WHAT MEDICATION, DRUGS, OR OVER-THE-COUNTER PREPARATIONS ARE YOU NOW TAKING?

(e.g. medicines for sleep, constipation, head-aches, birth control, anxiety, etc.) Please list:

PRIOR HOSPITALIZATIONS AND SURGERY (please give approximate dates):

SIGNATURE:

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

A copy of Dr. Julia Sabetta's Notice of Privacy is on our coffee table for your reading convenience.

I, ________________________________, have received a copy of Dr. Julia B. Sabetta's
Patient Name

Notice of Privacy Practices (4 pages, including this page).

____________________________________ ________________________

Signature of Patient Date