Patient Registration

	Account No. (Office Use Only)
Referred By	Date
How did you hear about us?	
Primary Care Provider Name/Office:	

Patient

Full Name			
Social Security No. (If known)	D.O.B.	Age	☐ Male ☐ Female
Mailing Address		Preferred Phone	
City, State, Zip		Pharmacy Phone	

Parents/Responsible Party

Name	Relationship to Patient
Employer	Phone
Email Address	
Spouse's Name	Relationship to Patient
Spouse's Employer	Phone
Email Address	

In Case of Emergency

Name	Relationship	Phone No.
Name	Relationship	Phone No.

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and most major credit cards.

Signature Date

Health History Form

Dr. _____

Name	Date

Address

D.O.B.	Age	Height	Weight	Reason for visit today?

Past/Current Hx (Check all applicable)

- ☐ Abnormal or Excessive Bleeding
- ☐ Asthma
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Dry Eyes
- ☐ Failure to Thrive/ Poor Weight Gain
- ☐ Fever Blisters
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Keloids
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Birth Weight
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ MRSA
- ☐ Neck Problems
- ☐ Prematurity
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Taken Accutane with in Past Year
- ☐ Twin/Triplet
- ☐ Use CPAP/BPAP

Other Major Illnesses/Diagnosis: _____

_____

Medications: Name	Reason for Taking	Frequency/Dose

Does child take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, What: _____

_____

_____

Allergies and Reactions to Medication? _____

_____

Previous Surgeries: _____

_____

_____

Has child or anyone in your family had complications from anesthesia? If Yes, please explain: _____

_____

_____

Has anyone in your family had breast cancer before the age of 50? If Yes, please explain: _____

_____

Has child been on ANY steroids in the last year? If Yes, please explain: _____

_____

Does your child take aspirin on a regular basis? ☐ Yes ☐ No

Does your child have excessive bleeding or bruising? ☐ Yes ☐ No

Does your child use any tobacco products? ☐ Yes ☐ No

Is your child pregnant? ☐ Yes ☐ No

Does your child have any teeth that are: ☐ Loose ☐ Fragile ☐ Capped ☐ False

Signature	Relationship to Patient	Date

Insurance Information

			Account No. (Office Use Only)
Patient Name			☐ Male ☐ Female
D.O.B.	Age	Social Security No. (If Known)	

Primary Insurance

Insurance Company			
Insured			Relation to Patient
D.O.B.	☐ Male ☐ Female	Social Security No.	
Insurance Claims Address			
Pre-Certification Phone No.			
Policy No.			Group No.

Secondary Insurance

Insurance Company			
Insured			Relation to Patient
D.O.B.	☐ Male ☐ Female	Social Security No.	
Insurance Claims Address			
Pre-Certification Phone No.			
Policy No.			Group No.

Assignment Of Benefits

I hereby assign all medical and / or surgical benefits for private insurance (Not to include Medicare, unless specific arrangements have been made) to: Pediatric Plastic Surgery Institute. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signature	
Dr.	Date