SCHLAM DERMATOLOGY P.A.
PATIENT REGISTRATION

THIS REGISTRATION FORM MUST BE FILLED OUT COMPLETELY

This form will be returned to you for completion BEFORE you see the Doctor if it is not complete.

Use "N/A" or "None" where necessary

Patient Name - If a minor the parent or person authorized to bring in minor must write their name there ⟶		**Parent or Person Authorized to Have Minor Receive Medical Care** [Photo ID of parent or authorized person is required]		
Date of Birth & Sex - Patient M ❑ F ❑		**Home Phone**	**Work Phone**	**Cell Phone [**MANDATORY**]**
How did you hear about us? ❑ Doctor _____ DOCTOR'S NAME ❑ Patient _____ PATIENT'S NAME	❑ Yellow Pages Phone Book ❑ YP.com Website ❑ Internet ❑ Our Website ❑ Bus Bench ❑ Employee ❑ Insurance ❑ Friend of staff ❑ Other _____	**Emergency Contact Name** **Phone:**		**Marital Status [Patient]** S M W Sep D **Spouse's Name:** _____
Street Address		**City**	**State**	**Zip Code**

INSURANCE INFORMATION

Insurance Company Name	ID Number	Group Number	Primary Insured's Name	Insurance Card Copied Today
				❑ Yes ❑ No

Patient's Employer [Parent's if patient is a minor] ❑ **Student**			**Work Phone**	**Spouse's Employer** ❑ **Student**			**Work Phone**
Work Address			**Occupation**	**Work Address**			**Occupation**
City		**State**	**Zip Code**	**City**		**State**	**Zip Code**

I hereby authorize Edward H. Schlam, M.D. and Evan H. Schlam, M.D., or any physician, physician assistant or other of their employees, to examine and treat me. I also hereby authorize such treatment and procedures as deemed necessary by the physician, including but not limited to the administering or taking of medications, blood samples or other in-office therapies and or procedures. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Dr. Edward H. Schlam or Dr. Evan H. Schlam to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company, be made directly to SCHLAM DERMATOLOGY P.A. without regard as to whether the Doctor is in network or out of network as so required by Florida law, (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked only in writing by either me or my insurance company at any time.

RECEIPT OF NOTICE OF PRIVACY PRACTICES - Written Acknowledgement
By my signature below, I certify that I have received a copy of SCHLAM DERMATOLOGY P.A.'s Notice of Privacy Practices.

I hereby certify that I understand all of the above authorizations:

Signature:_____ Date:_____
PATIENT (or) PARENT, GUARDIAN, INSURED or GUARANTOR

MUST BE FILLED OUT COMPLETELY, PLEASE

Patient Registration

Name _____ Age:_____

General Medical Information

CURRENT MEDICAL PROBLEM for today's visit: _____

Do you use aspirin or any blood thinners on a regular basis? ❑ **Yes** ❑ **No**

ALL current medications, vitamins & supplements, dosage for each & how taken: _____

_____

ALL Allergies to medications: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

_____

Do you smoke? ❑ No ❑ Yes ❑ Cigarettes ❑ Pipe ❑ Cigar

Do you regularly drink alcohol? ❑ Yes ❑ No

Do you regularly drink coffee? ❑ Yes ❑ No

Are you under a lot of pressure at work? ❑ Yes ❑ No Please describe: _____

Females only: Are you pregnant? ❑ Yes ❑ No Planning a pregnancy? ❑ Yes ❑ No Nursing a child? ❑ Yes ❑ No

For Doctor's Use Only
❑ Tobacco user was counseled on benefits of cessation.

Personal Medical History

Have you ever had any of the following (check all that apply)? ❑ Skin Cancer _____ ❑ Pre-Cancer_____

❑ Chest pain/pressure/tightening _____
❑ Hypertension _____
❑ Heart attack _____
❑ Stroke _____
❑ Headaches _____
❑ Glaucoma _____
❑ Allergies or Eczema _____
❑ Depression _____
❑ Blood in stool _____
❑ Other:
_____

❑ Asthma _____
❑ Dizzy Spells _____
❑ Cancer _____
❑ Diabetes _____
❑ Arthritis _____
❑ Difficulty hearing
_____
❑ Anemia _____
❑ Memory loss _____
❑ Hemorrhoids
_____

❑ Kidney disease
_____
❑ Shortness of breath
_____
❑ TB/Lung disorder
_____
❑ Ulcers
_____
❑ Skin disorders _____
❑ Hepatitis
_____
❑ Cataracts
_____
❑ Digestive problems _____
❑ Frequent urinary infections _____

❑ NONE of the above apply _____ [Initials]

Hepatitis C risk factors

❑ Blood transfusion prior to 1992
❑ IV drug use (1+ times)
❑ Contact with blood/bodily fluid
❑ Tattoos
❑ Shared razor/toothbrush
❑ Body piercing

❑ NONE of the above apply _____ [Initials]

Immunizations

Year last received, (if known)

Smallpox _____
Tetanus _____
Typhoid _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
HIGH BLOOD PRESSURE	❑	❑	❑	❑	❑	❑
EPILEPSY	❑	❑	❑	❑	❑	❑
CANCER	❑	❑	❑	❑	❑	❑

Polio	_____
Influenza	_____
Pneumonia	_____
Rubella	_____
Hepatitis	_____

❑ Immunizations are up-to-date _____ [Initials]

ECZEMA / PSORIASIS	❑	❑	❑	❑	❑	❑
HEART ATTACK / STROKE	❑	❑	❑	❑	❑	❑
DIABETES	❑	❑	❑	❑	❑	❑
ASTHMA	❑	❑	❑	❑	❑	❑
HAY FEVER	❑	❑	❑	❑	❑	❑

❑ NONE of the above apply _____ [Initials]