Patient Registration Form

PATIENT INFORMATION **Referring Physician**_____

Patient Name: Last_____ First _____ Middle _____

Address _____ City_____State_____ZIP_____

Sex: (Please Circle) Male/Female Title: (Please Circle) Dr. Mr. Mrs. Ms.

Social Security # ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Birth date ____ ____ - ____ ____ - ____ ____ Home Phone (_____)_____

Work Phone (_____)_____ Marital Status _____

Employer/Address _____ City _____ State _____

Emergency Contact _____ Phone Number (_____)_____

RESPONSIBLE PARTY

Guarantor's Name _____ Phone Number (_____)_____

Address _____City _____State_____ ZIP _____
(If different from above)
Patient Relation to Guarantor _____ Guarantor Employer _____

Employer Address: City _____ State _____ ZIP _____

Guarantor SS# ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Guarantor Birth date _____

PRIMARY
Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

SECONDARY

Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

I hereby authorize Seven Hills Dermatology , to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Seven Hills Dermatology, of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's signature (or responsible party) _____ Date _____

GARRETT RYNNING BOHRNSTEDT, D.O.

(434) 237-DERM (3376) | (434) 237-3330.FAX | WWW.SEVENHILLSDERMATOLOGY.COM
119-A TRADEWYND DRIVE | LYNCHBURG, VA 24502

PATIENT:_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other:

_____

_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral) Year: _____
Joint Replacement, Hip (Right, Left, Bilateral) Year: _____
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other:

_____

_____

PATIENT:_____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	
		NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Do you have a family history of other skin cancers? Yes No
If yes, explain, (ex. Mother – basal cell carcinoma, squamous cell carcinoma)
_____

Medications: (Please enter all current medications)
_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other_____

PATIENT:_____

Do you have any of the following: (please circle all that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Heart Valve
Artificial Joint Replacement within Last 2 Years
Currently take Blood Thinners
Pacemaker
Defibrillator
History of MRSA
Rapid Heartbeat with Epinephrine
Are you pregnant or currently trying to get pregnant?

Other:

Preferred Language:_____

Race:_____

Ethnic Group:_____

Preferred Pharmacy Name: _____

City or Zip Code: _____