NEW PATIENT REGISTRATION

Last Name, First Name _____Middle Initial_____ Nickname_____

SSN#: _____ Date of Birth: _____ Age: ____ Sex: M / F Marital Status: S M D W

Race: _____ Preferred language: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method: Cell phone_____ Home Phone _____ Work Phone _____

Email Address: _____Can we send you email regarding specials and events? ☐ Yes ☐ No

Preferred Appointment Confirmation Reminder: E-mail___ Phone___

Military: Y / N If yes, are you Retired? ☐ Yes ☐ No

Employer: _____ Occupation: _____

Guardian /Parent Name (if patient is under 18):_____

Guardian/Parent SSN#: _____ Guardian/Parent Date of Birth: _____

Emergency Contact: _____ Phone Number: _____

Do you have a Primary Care Physician? ☐ Yes ☐ No
If so, who? _____ Phone Number: _____

Were you referred by a Physician to our practice? ☐ Yes ☐ No
If so, who? _____ Phone Number: _____

Consumer Assistance Notice:
To report a complaint regarding the services you receive, please call the Agency for Health Care Administration toll-free: 1-888-419-3456 or go to ahca.myflorida.com. To Report abuse, neglect, or exploitation, please call the Florida Department of Children and Families toll-free: 1-800-962-2873. To report an unresolved complaint with a managed care entity, please contact the Subscriber Assistance Program at: 850-412-4502.

Signature of Patient or Parent/Guardian: _____Date: _____

COSMETIC MEDICAL HISTORY

Patient: _____ Date of Birth: ____/_____/_____ Chart#: _____

Do you have now or have you ever had any of the following past medical history?

	Y	N		Y	N		Y	N
Abnormal Bleeding/Bleeding Disorder	□	□	Lupus/SLE	□	□	Seizures/Fainting/Epilepsy	□	□
Anxiety/History of Anxiety	□	□	Pacemaker/ Defibrillator	□	□	***Please Specify**_____		
Hernia	□	□	Stroke	□	□	Other Medical Condition	□	□
High Blood Pressure	□	□	Fever Blisters/Cold Sores/Herpes Simplex	□	□	***Please Specify**_____		

Are you allergic to any medications? □ y □ n If yes, list below:

1._____2._____3._____

Please list all current medications and dosage (ie: prescriptions, acne medications, OTC medications, and vitamins):

1._____2._____3._____

4._____5._____6._____

Are you allergic to any of the following?

Local Anesthetic (lidocaine) □ y □ n Latex □ y □ n Adhesive Tape □ y □ n

Smoking History

□Current every day smoker □Former smoker
Current some day smoker □Never smoker

FEMALE PATIENTS ONLY

Are you pregnant? □ y □ n
Are you nursing? □ y □ n
Are you trying to become pregnant? □ y □ n

What is your reason for being seen today?_____

Patient Signature (or authorized representative): _____
Date ___/___/___

Pharmacy Name: _____ Phone: _____