VALLEY DERMATOLOGY CENTER

Patient Registration Form

Patient Last Name:	Patient First Name:	Date of Birth:	Social Security Number:
Mailing Address:	City:	State:	Zip Code:
Please Circle One: Male Female	Home Phone:	Cell Number:	Work Number:
Responsible Party (Applicable if Patient is under 18):		Employer's Name:	
Responsible Party Address (if different from above):		Responsible Party Telephone Number:	
Emergency Contact:	Relationship to the Patient:	Phone Number:	
Who referred you to this office?	**What is the reason for visit with Dr. Weiss?**		
Have you ever been treated by a dermatologist? □ Yes □ No	If so, for what problem?		

Please check any of the following conditions that you have had:

☐ Melanoma ☐ Allergy ☐ Asthma
□ Skin Cancer ☐ Liver Disease ☐ Tuberculosis
☐ Diabetes ☐ Eczema ☐ Kidney Disease
☐ Psoriasis ☐ Thyroid Condition ☐ Eye Disease
☐ High Blood Pressure ☐ Heart Disease ☐ Acne
☐ Other diseases (please list):

Please check any conditions that members of your family have had:

☐ Melanoma ☐ Allergy ☐ Asthma
□ Skin Cancer ☐ Liver Disease ☐ Tuberculosis
☐ Diabetes ☐ Eczema ☐ Kidney Disease
☐ Psoriasis ☐ Thyroid Condition ☐ Eye Disease
☐ High Blood Pressure ☐ Heart Disease ☐ Acne
☐ Other diseases (please list):

If you are taking any medications, please list:

If you are **allergic** to any medications, please list:

Please answer the following questions:

Are you pregnant? ☐ Yes ☐ No
Have you ever had surgery? ☐ Yes ☐ No
Have you ever fainted during a procedure or while receiving local anesthesia or an injection? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No
Have you ever had trouble with prolonged bleeding? ☐ Yes ☐ No
Have you ever had an unusual reaction to anesthetic or drugs (like penicillin)? ☐ Yes ☐ No
Have you ever had skin cancer or a mole with changes in color, size, shape, itching, or bleeding? ☐ Yes ☐ No

Is there any other medical information you wish to add? _____

THIS OFFICE DOES NOT BILL PRIVATE INSURANCE

Please check as appropriate:

☐ Self Pay ☐ Medicare # _____ ☐ Medicaid # _____ ☐Tricare/Champus

Signature of Patient or Responsible Party:	**Date:**

Do you give us permission to leave messages regarding your health on your answering machine? ☐ Yes ☐ No
E-mail Address:

Please list name(s) of family members and/or caregivers with whom we may discuss your medical condition: