Bella Dermatology
Patient Registration Form

Last Name:_____First Name:_____Date:_____

Middle Initial:_____ Date of Birth: _____ Gender: Male Female

Home Phone: _____ Work Phone:_____

Cell Phone: _____ Preferred Phone: HOME CELL

I consent to communicate by email to this E-mail Address: _____

Address: _____

City: _____State: _____Zip Code: _____

Preferred Pharmacy: Name _____Phone_____

Address_____

Referring/Primary Care Physician: Name_____Phone_____

Address _____

Employer: Name _____Phone_____

Insurance Company:

Primary Insurance Company_____**Subscriber Number_____**

Secondary Insurance Company_____**Subscriber Number_____**

<u>If your insurance is under a spouse or legal guardian, please fill out the following:</u>

Insured Person's Last Name _____First Name_____

Date of Birth _____

Mailing Address _____

City_____State_____Zip Code_____

Home Phone _____Relationship to Patient_____

Release of Health Information:

We may leave a message with test results at (Circle one): HOME CELL NONE

Bella Dermatology is permitted to release your medical information and records to:

Name _____Phone _____

Relationship to Patient: _____

I have an Advanced Directive: Yes No

Designated Surrogate Decision Maker: Name _____

Bella Dermatology
Medical History Form

Name_____ **Height _____ Weight _____**

List all blood thinner: Y N _____
List all allergies to medications: Y N _____
List all other known allergies Y N _____

Allergic to adhesives? Y N
Artificial Heart Valves? Y N
Artificial Joints? Y N
Allergic to Lidocaine? Y N
Pacemaker/Defibrillator? Y N
History of MRSA? Y N

Do you smoke? Y N
Are you a former smoker? Y N
Do you drink alcohol ? Y N
Do you use sunscreen? Y N

Female patients: Are you currently PREGNANT? Y N BREASTFEEDING? Y N

History of all Surgeries:_____

H**istory of SKIN CANCER with LOCATION and DATE:**
Basal Cell Carcinoma : _____

Squamous Cell Carcinoma (of skin) :_____

Melanoma:_____

Atypical Moles: _____

Family History of Skin Cancer: Y / N_____

Hay Fever/Seasonal Allergies Y N
Autoimmune disorders Y N
Problems with healing/scarring Y N
Bleeding Tendency Y N
Asthma Y N
Psoriasis Y N
Herpes/Cold Sores Y N
HIV Y N
Eczema Y N
Diabetes Y N
Glaucoma Y N
Cataracts Y N

Hepatitis TYPE _____ Y N
Convulsions/ Seizures Y N
Heart Attack Y N
High Cholesterol Y N
Hypertension Y N
Stroke Y N

Hyperthyroid/Hypothyroid Y N

Please list any other information we need to know about you or your health: _____

_____

I hereby acknowledge that I have read this form and I understand its contents.

SIGNATURE: _____ DATE:_____

Bella Dermatology
Medication List

Last Name: _____ First Name: _____ D.O.B._____

Please list any prescription medications and nonprescription medications you are currently on:

Medication	**Dosage**	**Frequency**
Non-Prescription Medication	**Dosage**	**Frequency**

I hereby acknowledge that the information given is up to date and current:

Signature:_____ Date:_____