

PATIENT REGISTRATION



Kathleen W. Judge, M.D.
Medical Director
Diplomate American Board of Dermatology
Dermatology and Dermatologic Surgery

LAST NAME	FIRST NAME	SSN#	DOB	AGE	DATE OF APPOINTMENT
ADDRESS		CITY	STATE	ZIP	SEX
HOME/ DAY PHONE	CELL PHONE	MARITAL STATUS	PRIMARY LANGUAGE		
DRIVERS LICENSE #	STATE	EMAIL ADDRESS			
EMPLOYER	EMPLOYER ADDRESS				

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

NAME	SSN#	DOB	AGE	
ADDRESS	CITY	STATE	ZIP	
SEX	RELATIONSHIP TO PATIENT			
HOME PHONE	DAY PHONE			
IN CASE OF EMERGENCY, PERSON TO CONTACT OTHER THAN SPOUSE			RELATIONSHIP	
ADDRESS	PHONE			

PRIMARY INSURANCE

NAME OF COMPANY	POLICY #	GROUP #	COPAY/ DED
ADDRESS OF INSURANCE COMPANY	CITY, STATE, ZIP		
NAME OF INSURED (AS IT APPEARS ON THE CARD)	RELATIONSHIP	PHONE #	DOB
ADDRESS OF INSURED	CITY, STATE, ZIP		SSN #

SECONDARY INSURANCE

NAME OF COMPANY	POLICY #		
NAME OF INSURED	RELATIONSHIP TO PATIENT	GROUP #	
ADDRESS OF INSURANCE COMPANY			
CITY, STATE, ZIP			

PHYSICIAN/ PHARMACY INFORMATION

PRIMARY PHYSICIAN	REFERRING PHYSICIAN
PREFERRED PHARMACY	PHARMACY PHONE NUMBER
LOCATION	

I hereby request the professional services of
CENTRAL FLORIDA DERMATOLOGY ASSOCIATES and agree to the financial responsibility as indicated in the paragraph below:
As a courtesy, our practice will file your insurance claim. However, it is your responsibility to supply us with the current and correct information and to know your policy requirements and limitations.

We only file insurance claims to plans in which we participate. If you are not covered by one of the insurance plans that we participate in, then payment is expected at the time services are rendered. Your signature authorizes the release of medical information necessary to process claims and also authorizes payment of medical benefits to the physician. If your insurance does not pay, you will become financially responsible for payment in full.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____ DATE: _____

MEDICAL HISTORY



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PLEASE CIRCLE ALL THAT APPLY:

Bronchitis	Pacemaker	Kidney Transplant	Intestinal Problems
COPD/ Emphysema	Heart Transplant	Dialysis	Bladder Problems
Asthma	Heart Valve Replacement	Seizures	Prostate Disease/ Cancer
Tuberculosis	Diabetes	Stroke	Joint Replacement
Lung Cancer	Liver Disease	Bleeding Disorder	Arthritis
Sarcoidosis	Liver Transplant	Thyroid Disease	Reproductive Tract
High Blood Pressure	Hepatitis	Depression	
Heart Disease	Kidney disease	Stomach Ulcers	

List any **other diseases or conditions:** _____

List all **medications:** (oral, injection, topical, including prescriptions, over-the-counter, and herbal) _____

List all previous **surgical procedures:** _____

List all **allergies:** _____

SKIN HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Have you ever had skin cancer? YES NO _____

Family history of skin cancer? YES NO _____

Do you have a history of skin diseases? YES NO _____

Do you have any problems healing? YES NO _____

Do you develop keloid/ raised scars after surgery? YES NO

Do you bleed easily? YES NO

When exposed to sun, do you: TAN TAN & BURN BURN

SOCIAL HISTORY

Do you smoke? YES NO If yes, how many packs per day? _____

Do you drink alcohol? YES NO If yes, how many drinks per day? _____

Are you pregnant? YES NO Due date: _____ Breastfeeding YES NO

 PRINT PATIENT NAME

 SIGNATURE OF PATIENT OR LEGAL GUARDIAN

 DATE

Reviewed By: _____
 (CFDA Initials)