

PATIENT REGISTRATION



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

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____
Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Sex Female Male
Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Policy Holder: _____ DOB _____ Patient Relationship to the Policy Holder: _____

Secondary Health Insurance Company _____

Policy # _____ Ins. Phone _____

Policy Holder: _____ DOB _____ Patient Relationship to the Policy Holder: _____

Physician/Pharmacy Information

Primary Physician: _____ Phone: _____ Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone _____

Location: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Central Florida Dermatology Associates to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Central Florida Dermatology Associates and myself.

Signature _____ **Date** _____

MEDICAL HISTORY



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

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)