# DERMATOLOGY AND ENT CENTER

## NEW PATIENT REGISTRATION FORM

**A. PATIENT INFORMATION.** **TODAY'S DATE** 05/26/2020/_____

NAME_____ DOB_____

GENDER_____ MARITAL STATUS_____ CELL PHONE _____ - _____

ADDRESS: _____ Apartment # _____

CITY_____ STATE_____ ZIP_____

WORK PHONE _____ - ._____ E-MAIL_____

REFERRING DOCTOR/PROVIDER _____ PHONE _____

**B. PARENT OR RESPONSIBLE PARTY (ONLY IF DIFFERENT FROM THE PATIENT).**

NAME_____ DOB_____

GENDER_____ MARITAL STATUS_____ CELL PHONE _____-_____

ADDRESS: _____ Apartment # _____

CITY_____ STATE_____ ZIP_____

WORK PHONE _____ - _____ E-MAIL_____

**C. HEALTH INSURANCE INFO.**

PRIMARY INSURANCE NAME_____ MEMBER ID # _____

EFFECTIVE DATE _____

SECONDARY INSURANCE NAME_____ MEMBER ID # _____

EFFECTIVE DATE _____

**D. PHARMACY NAME, ADDRESS, PHONE #**

_____

**Health History Form**

Name: _____

Date of Birth: 05/26/2020 Today's Date: _____

Do you have or have you ever had diseases or conditions of (please check Yes or No)

**Respiratory**:

| | | |
|---|---|---|
| Bronchitis | Yes | No |
| Emphysema | Yes | No |
| Asthma | Yes | No |
| Chronic Cough | Yes | No |
| Morning Cough | Yes | No |
| Shortness of Breath | Yes | No |
| Wheezing | Yes | No |

**Cardiovascular**:

| | | |
|---|---|---|
| High Blood Pressure | Yes | No |
| Chest Pain | Yes | No |
| Heart Attack | Yes | No |
| Heart Murmur | Yes | No |
| Arrhythmia | Yes | No |
| Phlebitis | Yes | No |
| Hardening of the Arteries | Yes | No |
| Artificial Valve | Yes | No |
| Pacemaker | Yes | No |

**Other Systemic**:

| | | |
|---|---|---|
| Hepatitis | Yes | No |
| Diabetes | Yes | No |
| Thyroid Problems | Yes | No |
| Kidney Disease | Yes | No |
| Dialysis | Yes | No |
| Bladder Problems | Yes | No |
| Gastrointestinal | | |
| Stomach absorptive disorder | Yes | No |
| Nausea, vomiting, diarrhea when taking antibiotics | Yes | No |
| Yeast infection when taking antibiotics | Yes | No |
| Arthritis/joint Deformity | Yes | No |
| Artificial Joint | Yes | No |
| Convulsions | Yes | No |
| Epilepsy, Seizures | Yes | No |
| Fainting | Yes | No |
| Depression | Yes | No |
| HIV | Yes | No |

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

List **Surgeries** _____

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

_____

_____

List all **Allergies**: _____

_____

**Skin**: Have you ever had skin cancer? Yes No _____

Family history of skin cancer? Yes No _____

Do you have history of skin diseases? Yes No _____

Do you have problems healing? Yes No

Do you develop keloid/raised scars after surgery? Yes No

Do you bleed easily? Yes No

Do you get rashes from Medication Food Environment Ointments Other _____

**Social History**:

Do you drink alcohol? Yes _____ / day No

Do you smoke? Yes How much? _____ No

Do you use IV drugs? Yes How much? _____ No

What is your occupation? _____ _____

(Women) Are you pregnant? Yes No Due date: ___/____/____ Breastfeeding: Yes No

_____

Have you ever seen a dermatologist before? Yes No Why? _____

Reason for your visit today? _____

_____

_____

DERMATOLOGY
SKIN CANCER SURGERY CENTER
VITALY BLATNOY, MD, FAAD

PATIENT EAR NOSE THROAT
MIKHAIL VAYSBERG, DO

# Informed Patient Consent

_____ I give my permission for Dr. Blatnoy, Dr. Vaysberg and staff of Dermatology and ENT Center to treat me as deemed necessary in the exercise of their professional judgment.
_____ I understand that medical care requires my cooperation.
_____ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.
_____ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical care to third party payers, including Medicare. Consistent with HIPPA regulations, any release will be limited to only those records required to obtain payment.
_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor or medical group any benefits for services rendered.
_____ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.
_____ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.
_____I received and read Notice of Privacy Practices.

_____ 05/26/2020
Patient Name (Print) Date

*422 South Alafaya Trl, # 26, Orlando, FL 32828*
*Tel. 407-538-3855. Fax 407-459-8732*

*7250 Red Bug Lake Rd, #1020, Oviedo, FL 32765*
*Tel. 407-706-1770. Fax 407-706-1777*

*731 Stirling Center Place, # 1931. Lake Mary, FL 32746*
*Tel. 407-436-7375. Fax 321-363-0018*