MILFORD MD
Skin & Laser Center / Advanced Dermatology
Pocono Medical Care, Inc.
www.milfordmd.com

Patient Registration Form

Please present your Insurance/Medicare cards and driver's license or other photo ID upon registration.
Please print the information requested below.

Name: (last) ____ (first)________________________ (m)______

How would you like to be addressed? ________________________________

Birth date: ________________ Age: _____ **SS:**________________________

□ Male □ Female **Marital Status:** □ M □ D □ W □ S □ Partnered for ______years

Phone: **H** _____-___________________ **W** _____-___________________ **C** _____-___________________

E-Mail:____

Occupation: _________________________________ Employer ___________________________________

Mailing Address:____

City:_____________________________________State____Zip__________

Physical Address:____

City:_____________________________________State____Zip__________

Vacation or 2nd Address: ____

City:_________________________________State____Zip________ Phone: _____-____________________

Emergency Contact: _______________________________________ Phone: _____-____________________

Nearest relative not living with you: _________________________ Phone: _____-____________________

Address:____

Primary Health Insurance:___________________________ Secondary: ______________________________

Payment: If we do not participate with your insurance or if you have not presented your insurance card, you will pay the facility's regular rates, in full, at the time of service. If we participate with your insurance company, **co-pays and deductibles must be paid at the time of service** and your primary insurance company will be billed. You are responsible for billing any secondary insurance you may have and are responsible for any additional monies owed after we receive your insurance company's payment (e.g. non-covered services). Our professional services are rendered for and charged directly to you, not your insurance company and you agree to be responsible for payments. Payment may be made by **CASH, CHECK OR CREDIT CARD**. If we are not a participating provider, a receipt will be given to you, suitable for you to submit to your insurance carrier. **You agree that cosmetic services will not be billed to your insurance company and that you are responsible for full payment before or at the time of service.**

Outside Services: Independent outside laboratory services (e.g. Quest Diagnostics) will bill you directly for any lab work. A cardiology and/or radiology group may provide an interpretation and will bill you directly for any in office testing (e.g. ultrasounds, echocardiograms).

Signature on File: I, the undersigned, request that payment of Insurance/Medicare benefits be made on my behalf to Pocono Medical Care, Inc. for any services rendered to me by this practice and its physicians. I authorize any holder of medical information about me to release to my health insurance company or the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge receipt of a copy of this office's *Notice of Privacy Practices* (HIPPA) and *Payment Policy*, consent to examination and treatment and agree to be financially responsible for the services rendered.

Patient/Parent/Guardian Signature:____ Date:___________________

Relationship:____________________________________

MilfordMD Skin & Laser Center
Name ______________________________________ DOB _____________

● **CHIEF COMPLAINT**: ***(DESCRIBE SYMPTOM(S) OR CONDITION(S) FOR WHICH YOU ARE SEEING THE DOCTOR)***

____

● **PRESENT/PAST MEDICAL HISTORY**: ***(LIST CONDITIONS AND DATE)***

____

____

SURGICAL HISTORY: ***(LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)***

____

____

● **DRUG ALLERGIES**: (LIST TYPE OF REACTION)

ANESTHETICS______________________________ ASPIRIN______________________________

CODEINE______________________________ ERYTHROMYCIN______________________________

PENICILLIN______________________________ SULFA______________________________

TETRACYCLINE______________________________ OTHERS, *please list*______________________________

● **NON-DRUG ALLERGIES:** LATEX OTHER *(SPECIFY)*______________________________

PRE-MEDICATION REQUIRED PRIOR TO SURGERY NO YES - *List drug, dosage & duration*______________________________

● **ARE YOU CURRENTLY TAKING MEDICATION?** YES NO

If so, please list your medications, drugs, or over the counter preparations/remedies?

MEDICATION	DATE STARTED	DOSAGE (Milligrams)	HOW OFTEN

DO YOU HAVE A PACEMAKER OR INTERNAL DEFIBRILLATOR? YES NO

● **SOCIAL HISTORY**: ***(CHECK ALL THAT APPLY)***

Do you smoke? NO YES - Frequency______________ **Do you use recreational drugs?** NO YES - Frequency______________

Do you drink alcohol? NO YES - Frequency______________ **Hobbies**______________________________

● **FAMILY HISTORY**:

MOTHER: living deceased / age_______ **FATHER:** living deceased / age ________

BROTHERS/SISTERS - ages: ______________________ **NUMBER OF CHILDREN & ages**______________________

CHECK THE FOLLOWING MEDICAL CONDITIONS THAT HAVE OCCURRED IN YOUR FAMILY:

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Hayfever			

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Heart Disease			
High Blood Pressure			
Lung Disease			
Malignant Melanoma			
Psoriasis			
Skin Cancer			
Tuberculosis			

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Name ______________________________________ DOB _____________

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY: ***(INDICATE ALL BELOW THAT APPLY; USE C. IF CURRENT, USE P IF PAST)***

CONSTITUTIONAL SYMPTOMS:

____ Fever ____ Hair loss
____ Weight loss ____ Weight gain
____ Chills ____ Tremor
____ Nutritional Deficiencies
____ Other, specify_______________

EYES:

____ Cataracts ____ Glaucoma
____ Eyestrain ____ Blurring
____ Inflammation
____ Wear glasses
____ Wear contacts
____ Other, specify_______________
Date of last eye exam_______________

EARS, NOSE, MOUTH, THROAT:

____ Hearing difficulty
____ Pain ____ Discharge
____ Tinnitus (ringing in ears)
____ Dizziness ____ Wear hearing aid
____ Sinusitis ____ Postnasal drip
____ Obstruction
____ Gum Disease
____ Chronic sores
____ Herpes simplex infections
____ Soreness ____ Redness
____ Hoarseness
____ Other, specify_______________

CARDIOVASCULAR:

____ Stroke ____ Palpitation
____ Pacemaker/Defibrillator
____ Heart Attack (MI)
____ Rheumatic Fever
____ Faintness ____ Pain
____ High blood pressure
____ Heart surgery
____ Edema (swelling)
____ Heart valve replacement
____ Other, specify_______________

INFECTIOUS:

____ HIV Positive ____ AIDS Virus
____ Hepatitis

RESPIRATORY:

____ Asthma ____ Chest pain
____ Emphysema ____ Tuberculosis
____ Lung disease
____ Breathing disorder
____ Bronchitis, chronic
____ Sputum, with blood
____ Cough, chronic
____ Upper respiratory infection, chronic
____ Other, specify_______________

GASTROINTESTINAL:

____ Ulcer ____ Pain
____ Nausea ____ Constipation
____ Diarrhea ____ Vomiting
____ Appetite decrease
____ Colon/intestinal disorder
____ Other, specify_______________

GENITOURINARY:

____ Discharge ____ Urgency
____ Sores ____ Incontinence
____ Hesitancy
____ Herpes simplex infections
____ Other, specify_______________

MUSCULOSKELETAL:

____ Arthritis ____ Lupus
____ Joint pain ____ Lupus of the skin
____ Weakness ____ Joint swelling
____ Joint replacement
____ Cold sensitivity
____ Other, specify_______________

INTEGUMENTARY:

____ Scarring/keloids
____ Herpes simplex (cold sores)
____ Acne / Cystic ____ Hives
____ Accutane Use (past or current)
____ Skin cancer(s) Malignant Melanoma
____ Warts Contact dermatitis
____ Eczema Psoriasis
____ Loss of Pigment
____ Other, specify_______________

NEUROLOGICAL:

____ Headaches ____ Convulsions
____ Seizures ____ Migraine headaches
____ Epilepsy ____ Fainting spells
____ Memory loss
____ Other, specify_______________

PSYCHIATRIC:

____ Stress ____ Depression
____ Nightmares ____ Insomnia
____ Anxiety ____ Suicidal Tendency
____ Treatment of psychological disorder
____ Other, specify_______________

ENDOCRINE:

____ Thyroid disorder
____ Diabetes mellitus
____ Excessive hair, face/body
____ Other, specify_______________

HEMATOLOGIC/LYMPHATIC:

____ Anemia ____ Bruise easily
____ Blood clots ____ Excessive bleeding
____ Other, specify_______________

ALLERGIC/IMMUNOLOGIC:

____ Asthma ____ Frequent infections
____ Allergies ____ Thyroiditis
____ Vitiligo ____ Addison's Disease
____ Pernicious anemia
____ Hay Fever
Other, specify_____________

MALES ONLY:

____ Prostatic problems

FEMALES ONLY:

____ Currently pregnant
____ Currently taking oral contraceptives
____ Last Mammogram
____ Last PAP Smear
____ Number of pregnancies
Date of last menses________

CANCER(S): ***(LIST TYPE, DATE, TREATMENT:***____

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