# Patient Registration Form

Patient Name:_____Birthdate:_____Age:_____

Address:_____ Apartment: _____

City: _____State: _____ZIP:_____

Home Phone: _____Work Phone: _____ Cell:_____

Email: _____

Patients SSN: _____Sex: M/ F; Race_____ Marital Status:_____

What are you being seen for today? _____

Who may we thank for referring you?_____

Emergency Contact Name & Phone:_____

Emergency Contact Address: _____

Employer Name: _____

Employer Address:_____

**I am also interested in:** _____ Skin Care Treatments _____ Skin Care Products

_____ Chemical Peel _____ Radiesse®-dermal filler _____ Juvederm-dermal filler

_____ Botox®- wrinkle reducer _____other : _____

**Authorization to Release Information/Authorization to Pay**: I hereby authorize Larry C. Leverett M.D. to release any information that may be requested by my insurance company, if applicable, to process claims submitted for my care provided by Dr. Leverett. I also authorize my insurance company to pay Dr. Larry Leverett, M.D. directly for the surgical and/or medical benefits, if any, otherwise payable to me for services.

I understand that I am financially responsible for all charges incurred, including charges denied by my insurance company, if applicable. Furthermore, I agree to pay any billed balance within 30 days or my account may be sent to collections. Accounts turned over to collections will incur a 30% of the balance for the collection fee. I agree to pay all attorney fees and court costs incurred to enforce collection of any amounts outstanding.

**Signed: (Patient or Parent, if minor)_____ Date:_____**

# Patient Personal History

Last Name _____First _____ Middle_____

Age_____ Ht_____ Wt_____ Sex: F / M # Children_____

Drug or food allergies: _____
_____

Primary Physician: _____Phone: _____

Do you have or have you had: (if yes, give date of occurrence)

| | | | |
|---|---|---|---|
| | | | ____ Cancer |
| _____ Stroke | _____ Migraine | _____ Rheumatic Heart | ____ Asthma |
| _____ Pneumonia | _____ Hay Fever | _____ Bleeding Tendency | ____ Hepatitis |
| _____ Diabetes | _____ Stomach Ulcers | _____ High Blood Pressure | ____ TB |
| _____ Leukemia | _____ Tonsillitis | _____ Congenital Heart | ____ Goiter |
| _____ Bronchitis | _____ Bladder Infection | _____ Arthritis | ____ Colitis |
| _____ Heart Attack | _____ Kidney Disease | _____ Nervous Breakdown | ____ Epilepsy |

Do you know of any blood relative that has or had any of the above conditions? If yes, please state condition and relationship_____
_____

Date of last chest x-ray _____ Do you have nosebleeds? Y N
Do you regularly smoke? Y N How much? _____ For how long? _____
Do you usually drink over 6 cups of coffee per day? Y N
Do you regularly drink alcohol or beer? Y N How much? _____
Do you regularly take aspirin, Bufferin, Anacin? Y N How much?_____
Do you or have you ever had a drug addiction? Y N
Do you frequently have bleeding gums? Y N

List any serious illnesses you have had _____
_____
Name and year of any operation you have had, including past cosmetic procedures_____
_____

Circle any of the following medication / vitamins you are now taking:

| | | |
|---|---|---|
| cortisone | Blood pressure pills | iron |
| Digitalis | Cough medicine | sleeping pills |
| tranquilizers | insulin or diabetes pills | headache pills |
| Dilantin | thyroid medicine | blood thinning pills |
| barbiturates | water pills | weight reduction pills |
| shots | birth control pills | Phenobarbital |
| antibiotics | aspirin | St. John's Wort |
| Vitamin E. | multi vitamin | other _____ |

List Drug Name Dosage Frequency
_____
_____
_____
_____
_____
_____