Patient Registration Form
Northern Jersey Facial Plastic Center

This information is confidential and will not be released without your authorization

Date: _____

Name_____DOB_____ Age _____ SSN_____
LAST FIRST MIDDLE
Address:_____APT__CITY_____ZIP_____

Telephone: HOME_____CELL_____OFFICE_____EMAIL_____

Ht_____ Wt_____ Sex: M___ F____ Marital status: Single___Married___Other_____

Insurance:
Primary_____ ID#_____Group #_____Policy Holder:_____
Secondary:_____ ID#_____Group#_____ Policy Holder: _____
Emergency Contact: _____ Phone Number_____
How did you find us?_____ Reason for consultation_____

PAST MEDICAL HISTORY: Do you have or have you had? (If yes, give date of occurrence.)

AIDS or HIV	N	Y_____	Bleeding tendencies	N	Y_____	Asthma	N	Y_____
Thyroid	N	Y_____	Blood pressure	N	Y_____	Lupus	N	Y_____
Heart	N	Y_____	Lungs	N	Y_____	Cancer	N	Y_____
Kidneys	N	Y_____	Nervous problems	N	Y_____	Fibromyalgia	N	Y_____
Gallbladder	N	Y_____	Bleeding problems	N	Y_____	Arthritis	N	Y_____
Stomach	N	Y_____	Diabetes	N	Y_____	Scleroderma	N	Y_____
Hepatitis	N	Y_____	Other serious illnesses you have had_____					

Do you regularly smoke? Y N How much per day?_____
Do you regularly drink over 3 cups of coffee per day? Y N
Do you regularly drink alcohol or beer? Y N How much per week?_____

MEDICATIONS: Are you presently taking any of the following? (Circle.)

Aspirin/Anacin	Cough medicine	Antibiotics	Phenobarbital	Dilantin
Bufferin	Thyroid pills	Blood pressure pills	Blood thinners	Iron
Motrin	Hormones	Insulin/diabetic pills	Digitalis	Sleeping pills
Ibuprofen	Birth control pills	Arthritis medication	Cortisone	Water pills

Other medication not listed_____
Do you take herbal supplements? Y N If yes, what are they?_____
Aspirin and aspirin type products can cause excessive bleeding during surgery.
DRUGS OR SUBSTANCES TO WHICH YOU ARE ALLERGIC_____

FAMILY HISTORY: Have blood relatives had? (Please circle and give reason.)

High blood pressure_____	Arthritis_____	Asthma_____
Diabetes_____	Stroke_____	Goiter_____
Bleeding disorders_____	Breast cancer_____	Other cancer_____

SERIOUS ILLNESSES OR INJURIES: Please list any serious illnesses or injuries and dates.

Illness/Injury_____	Year_____	Illness/Injury_____	Year_____
Illness/Injury_____	Year_____	Illness/Injury_____	Year_____

OPERATIONS: Please list operations and year.

I HAVE READ AND COMPLETED THIS FORM COMPLETELY AND ACCURATELY TO THE BEST OF MY ABILITY

PRINT NAME_____SIGNATURE_____