ALBANY DERMATOLOGY CLINIC

PATIENT REGISTRATION FORM

Date: ______________

PATIENT NAME: ______________________________
Last First Middle

Address: ______________ City: ______________ State: ______ Zip: ______________

Home Phone: (______) ______–______ Work Phone: (______) ______–______, ext.: ______

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Date of Birth: ______/______/______ Age: ______ Social Security #: ______–____–______

PATIENT'S EMPLOYER: ______________________________

Employer Address: ______________ City: ______________ State: ______ Zip: ______________

Who is responsible for bill (if other than patient)?

(If minor child of divorced couple, parent accompanying child will be responsible for the bill.)

Name: ______________ Relationship to Patient: ______________

Address: ______________ City: ______________ State: ______ Zip: ______________

Home Phone: (______) ______–______ Work Phone: (______) ______–______, ext.: ______

Employer: ______________________________

Employer Address: ______________ City: ______________ State: ______ Zip: ______________

Nearest relative not living at the same address as patient: ______________ Phone: ______________

Address (including Apt. #): ______________________________

Were you referred to us by another doctor? ☐ No ☐ Yes *(please complete)*: Name: ______________

Address: ______________ Phone: ______________

MEDICAL INFORMATION:

Does patient have history of skin cancer? ☐ No ☐ Yes *(please describe)*: ______________

Is there a family history of skin cancer? ☐ No ☐ Yes *(please describe)*: ______________

Do you want a full skin check today? ☐ Yes ☐ No

Please list area of body that has lesions that concern you: ______________

Please list reason for your visit today: ______________

Do you have any of the following conditions? Please check "Yes" or "No":

Condition	Yes	No	Condition	Yes	No
Allergies to local anesthetic	☐ Yes	☐ No	Heart Condition	☐ Yes	☐ No
Abnormal bleeding	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	If "Yes", what type: ______________		
HIV	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No	Sarcoid	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Keloids	☐ Yes	☐ No

Is the patient pregnant? ☐ Yes ☐ No

List any medications to which you are allergic: ______________________________

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