

**DiBELLO PLASTIC SURGERY**  
PATIENT REGISTRATION FORM  
(PLEASE PRINT CLEARLY)

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ Spouse's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ Preferred method of contact: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Emergency Contact (Not in your household): \_\_\_\_\_ Telephone #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
How did you hear about Dr DiBello? \_\_\_\_\_

**REFERRAL INFORMATION**

Referred By:

Family Physician/Primary Care Physician:

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

**HEALTH INFORMATION**

Reason for your visit today: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Are you a smoker? \_\_\_ Y \_\_\_ N If yes, how much? \_\_\_\_\_

Are you pregnant, possibly be pregnant, or taking birth control pills? \_\_\_ Y \_\_\_ N \_\_\_ NA

Medical History: Do you have or have you had any of the following? (Circle yes or no)

Rheumatic Fever	Y	N	Heart Trouble	Y	N	Heart Murmurs	Y	N	Abnormal Scarring	Y	N
Heart Palpitations	Y	N	Irregular Heart Beat	Y	N	Chest Pains	Y	N	Bleeding Problems	Y	N
Shortness of Breath	Y	N	Swelling of Ankles	Y	N	High Blood Pressure	Y	N	Emotional Problems	Y	N
Diabetes	Y	N	Cancer	Y	N	Kidney Problems	Y	N	Psychiatric Problems	Y	N
Eye Diseases	Y	N	Hepatitis	Y	N	Thyroid Problems	Y	N	Blood Transfusions	Y	N
Asthma	Y	N	Anemia	Y	N	Blood Disorders	Y	N	Sexually Transmitted Diseases	Y	N

Trouble with dryness, soreness, burning, itching or excessive tearing of eyes? \_\_\_ Y \_\_\_ N Seasonal allergies? \_\_\_ Y \_\_\_ N

Chronic lung or bronchial disease? \_\_\_ Y \_\_\_ N Any other serious illness? \_\_\_ Y \_\_\_ N

If you answered yes to the above, please explain: \_\_\_\_\_

Previous surgery (list type/s and date/s): \_\_\_\_\_

Allergies: Are you allergic to or have you ever had an allergic reaction to any medication, drug or local anesthetic? \_\_\_ Y \_\_\_ N

If yes, please list medication & reaction: \_\_\_\_\_

Medications: List any medications you are currently taking or have previously taken on a regular basis (include aspirin, herbal supplements, vitamins, etc.) \_\_\_\_\_

Family Medical History (father, mother, grandparents, siblings, children): \_\_\_\_\_

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**AUTHORIZED SIGNATURE (if patient is a minor or unable to sign)**

\_\_\_\_\_  
**RELATIONSHIP TO PATIENT**