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/SO's Name:____________________________

Address:____ City:___________________ State: _________ Zip:____________

Telephone: Home: __________________________ Work __________________________ Cell _________________________________

E-Mail Address: ____ **Preferred method of contact**: ________________________

Emergency Contact: ________________________________ Telephone #:_________________________ Relationship: ___________________

Your Occupation:___________________________ Employer:________________________ Address: ___________________________________

How did you hear about Dr DiBello? ____

Pharmacy Name and Location:____ Pharm Phone:__________________________

PHYSICIAN INFORMATION

Referred By:

Name: ____

Address: ____

____

Telephone: ____

Family Physician/Primary Care Physician:

Name: ____

Address: ____

____

Telephone: ____

HEALTH INFORMATION

Reason for your visit today: ____

Height: __________ **Weight**: _________ **Are you a smoker?** _____ Y _____ N If yes, how much?__________________________

Smoking Status (please circle one): Every day Some Days Former Smoker Never Smoked Chewing Tobacco

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	Blood Clot History	Y	N

Trouble with dryness, soreness, burning, itching or excessive tearing of eyes? ____Y ____ N Seasonal allergies? _____ Y _____ N

If you answered yes to any of 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.)

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

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____ ____________________________

PATIENT SIGNATURE **DATE**

____ ____________________________

AUTHORIZED SIGNATURE (if patient is a minor or unable to sign) **RELATIONSHIP TO PATIENT**
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