## **DIBELLO PLASTIC SURGERY**

PATIENT REGISTRATION FORM (PLEASE PRINT CLEARLY)

Trouble with dryness, soreness, burning, itching or excessive tearing of eyes?YN Seasonal allergies?YN If you answered yes to any of the above, please explain:	Date:					(.			022,		,					
Address:   City:   Call	Name:	Date	Date of Birth:				Social Security #:									
Telephone:   Work   Cell   E-Mail Address:   Preferred method of contact:   Emergency Contact:   Telephone #:   Relationship:   Your Occupation:   Address:   How did you hear about Dr DiBello?   Pharmacy Name and Location:   Pharm Phone:	Age: S	ex:	M	_ F	Marital Status:	S	M	11	D W	/ S	pouse/S	O's N	ame:			
Telephone:   Work   Cell   E-Mail Address:   Preferred method of contact:   Emergency Contact:   Telephone #:   Relationship:   Your Occupation:   Address:   How did you hear about Dr DiBello?   Pharmacy Name and Location:   Pharm Phone:	Address:							City	/:				State:	Zip:		
Emergency Contact: Telephone #: Relationship:  Your Occupation: Employer: Address: How did you hear about Dr DiBeilo?  Pharmacy Name and Location: Pharm Phone: Pharm Phone: Pharmacy Name and Location: Pharmacy Name and Location: Pharmacy Name and Location: Pharmacy Name: Address: Pharmacy Name: Name																
Your Occupation:	E-Mail Address:								Pr	eferre	ed meth	od of	contact:			
Pharmacy Name and Location:	Emergency Conta	ct:				Te	lephor	ne #:					_ Relationship	:		
Pharmacy Name and Location:  Physician Information  Referred By:  Pamily Physician/Primary Care Physician:  Name: Address: Address: Address: Address:  Telephone:  HEALTH INFORMATION  Reason for your visit today: Height: Weight: Are you a smoker? Y N 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: Medical History: Y N Heart Trouble Y N Heart Trouble Y N Heart Humurus: Y N Abnormal Scarring Y N Heart Foreign A Heart Beat Y N Chest Pains Y N Bloeding Problems Y N Diabetes Y N Cancer Y N High Blood Pressure Y N Emotional Problems Y N Diabetes Y N Anemia Y N Thyroid Problems Y N Blood Clot History Y N Ashma X 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 N If you answered yes to any of the above, please explain:  Previous surgery (list type/s and date/s):  Medical History:  Medical	Your Occupation:_				Emp	oloyer:_					_ Addres	ss:				
Referred By: Family Physician/Primary Care Physician:    Name:	How did you hear	about Dr	r DiBel	llo? _												
Referred By:    Name:	Pharmacy Name a	and Loca	ition:								Pr	arm P	hone:			
Referred By:    Name:						54046										
Name: Address:    Address:   Address:   Address:   Address:						PHYS	SICIAI	N INFO	DRMATI	<u>ION</u>						
Address:				_							_	_	-	-		
Telephone:																
Reason for your visit today:    Height:	Address							'	Auuless.							
Reason for your visit today:  Height: Weight: Are you a smoker? Y N	Telephone:								Telephor	ne:						
Reason for your visit today:  Height: Weight: Are you a smoker? Y N																
Height:						<u>HE</u>	<u>ALTH</u>	<u>INFOF</u>	RMATIC	<u> </u>						
Height:	Reason for your	visit tod	av <sup>.</sup>													
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 Bleeding Problems 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):  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):	-		_								If ves	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 Blood Clot History Y N Trouble with dryness, soreness, burning, itching or excessive tearing of eyes?YN Seasonal allergies?YN If you answered yes to any of the above, please explain:  Previous surgery (list type/s and date/s):													onewii	ig Tobacco		
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.)  Family Medical History (father, mother, grandparents, siblings, children):		-	-	-	_	-	-				1	`				
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 Sye 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:	-	-			-			-	-	-	V	N	Abnormal S	carring	V	, NI
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:				Irre	egular Heart Beat	Υ	N						Bleeding Pr	oblems		
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:																
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:								Kidne	ey Proble id Proble	ms	Y					
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.)  Family Medical History (father, mother, grandparents, siblings, children):	Asthma				•											
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.)  Family Medical History (father, mother, grandparents, siblings, children):	Trouble with dryne	ess, sore	ness,	burnir	ng, itching or exce	ssive te	earing	of eyes	s?	Υ	N	S	seasonal allerg	ies?`	Υ	N
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?YN   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):	-				-		_	-					·			
Allergies: Are you allergic to or have you ever had an allergic reaction to any medication, drug or local anesthetic?YN  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):		,	•		,, ,											
Allergies: Are you allergic to or have you ever had an allergic reaction to any medication, drug or local anesthetic?YN  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):	Previous surgery	(list type	e/s an	d date	e/s):											
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):					,											
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):	Allergies: Are you	u allergic	c to or	have	you ever had an a	allergic	reaction	on to a	ny medic	ation.	, drug or	local	anesthetic?	Υ	N	
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):		_				_			-		_		_			
Family Medical History (father, mother, grandparents, siblings, children):	, , ,															
Family Medical History (father, mother, grandparents, siblings, children):	Medications: List	t anv me	dicatio	ns vo	u are currently ta	kina or	have r	oreviou	slv taken	on a	regular	basis	(include aspiri	in. herbal sur	plemer	nts.
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	vitamins, etc.)	, , ,		- ,	,	3			,		3.		(	,		,
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~																
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~																
PATIENT SIGNATURE DATE	Family Medical H	istory (fa	ather,	moth	er, grandparents,	siblings	s, child	dren):								
PATIENT SIGNATURE DATE																
PATIENT SIGNATURE DATE																
PATIENT SIGNATURE DATE	~~~~~~		~~~~	~~~~	-~~~~~~~	~~~~	~~~~	-~~~~	-~~~~	~~~~	~~~~~	~~~~	~~			
PATIENT SIGNATURE DATE																
	PATIENT SIGNATU	RE								DA	ATE					

RELATIONSHIP TO PATIENT

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