Richard A. Cirelli, M. D., F.A.A.D. Dermatology
Patient Registration Form

Patient Information (Please Print)

Name ______________________________ Social Security # ______ / ____ / ______
Last First MI

Age ______ Date of Birth ____ / ____ / ______ Marital Status ***Please Circle*** S M D W Gender Male _______ Female _______

Mailing Address ______________________________
City State Zip

Physical Address ______________________________
City State Zip

Home Phone ( ) ______________ Cell Phone ( ) ______________

Employer Name (Company) ______________________________ Employer Phone ( ) ______________

Employer Address ______________________________
City State Zip

Referring Physician ______________________ Primary Care Physician ______________________

Parent (for all patients under age 18) or Spouse Information

Name ______________________________ Social Security # ______ / ____ / ______
Last First MI

Date of Birth ____ / ____ / ______ Mailing Address ______________________________
City State Zip

Home Phone ( ) ______________ Cell Phone ( ) ______________

Employer Name (Company) ______________________________ Employer Phone ( ) ______________

Employer Address ______________________________
City State Zip

Do we have permission to:

Leave Message with medical information on home machine? _______ Yes _______ No
May we call you at work? _______ Yes _______ No
Discuss your medical condition with a member of household?: _______ Yes _______ No

If Yes, With whom? ______________________________
Treat minor child in the absence of parent/responsible party? _______ Yes _______ No

Insurance Information (please present insurance card at time of check in)

Primary Insurance Name ______________
Policy #: ______________ Group # ______________
Name of Insured ______________
Insured's Date of Birth ______________
Social Security Number ______________
Relationship of Insured to Patient
_______ Self _______ Parent _______ Spouse

Secondary Insurance Name ______________
Policy # ______________ Group # ______________
Name of Insured ______________
Insured's Date of Birth ______________
Social Security Number ______________
Relationship of Insured to Patient
_______ Self _______ Parent _______ Spouse

I, the undersigned, hereby authorize assignments of and direct billing to Medicare and/or other insurance benefits to Richard A. Cirelli, M.D., P.C. to obtain and release any medical and billing information to Medicare and/or other insurers necessary to process my claim(s), including determining eligibility and seeking reimbursement for services provided. I understand my healthcare information may be released to other physicians for treatment or knowledge or other reason which is required for the operation of our office. I request that payment of authorized benefits be made to Richard A. Cirelli, M.D., P.C. on my behalf, for services furnished to me. I certify I understand this office is required to maintain the privacy of my health information and upon my request provide me a copy of its legal duties and privacy practices. I understand and accept the terms of Richard A. Cirelli, M.D., P.C. office billing policy. If my insurance company reimburses me directly instead of Richard A. Cirelli, M.D., P.C., I will submit payment in the same amount to Richard A. Cirelli, M.D., P.C. I permit a copy of this authorization may be used in place of the original. I also understand that I am financially responsible for any and all charges whether or not covered by my insurance company. I certify I have read and accept the conditions set forth in this document.

Patient or Responsible Party Signature: ______________________________ **Date:** ______________

Medicare Patients with Medigap Coverage

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Richard A. Cirelli, M.D. P.C. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

Medicare Beneficiary Signature ______________________________

Revised 03/11/09

Patient's Medical History Sheet

Please fill out the following protected healthcare information:

Patient's Name: ____Date of Birth: ________________________________

Social Security #: ____ Height: ________________ Weight: ________________

Please complete the following to the best of your knowledge:

ALLERGIES:

Are you sensitive or allergic to: (Please Circle)

Penicillin	Yes	No	Codeine	Yes	No
Sulfa	Yes	No	Lidocaine Anesthetic	Yes	No

Please list any other drugs you may be allergic ____

MEDICATIONS: Please list all medications you are currently taking and the reason for taking the medication.

PLEASE PRINT Medication		PLEASE PRINT Taken For:

List any additional medications and the reason for taking the medication on a separate sheet.

Do you take aspirin, or a product which contains aspirin? YES / NO

WOMEN:

Are you pregnant or nursing? YES / NO

HISTORY:

Do you have a personal history of Skin Cancer? (Please Circle)

BCC (Basal Cell Carcinoma) YES / NO

SCC (Squamous Cell Carcinoma) YES / NO

Melanoma YES / NO

If Melanoma is circled YES, please list the year and location______________________________________

Please list other medical conditions including any cancer and cancer treatment:

____

____

Please list any major surgeries in the past ten years with approximate dates, for example, hysterectomy (2001):

____

____

Personal social history:

Do you drink alcohol? YES / NO Number of drinks per day? _______________

Do you smoke cigarettes? YES / NO Number of packs per day? _______________

Please list any family history of major medical conditions **including all cancers**, for example, melanoma (mother), stomach cancer (father)

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REVIEW OF SYMPTOMS: (Please Check the Applicable Box)

Constitutional		**Musculoskeletal**		**GU**	
Fever	Yes ☐ No ☐	Joint pain and/or swelling	Yes ☐ No ☐	Yeast infections from antibiotics	Yes ☐ No ☐
Fatigue	Yes ☐ No ☐				
		Eyes/Ears/Nose/Mouth Throat		**Immunologic/Heme**	
Cardiovascular		Cataracts	Yes ☐ No ☐	Allergies	Yes ☐ No ☐
Leg swelling	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Asthma history	Yes ☐ No ☐
Uncontrolled high blood pressure	Yes ☐ No ☐				
		Skin/Breast		**Neuro/Psyche**	
Respiratory		Rash from bandages, tapes	Yes ☐ No ☐	Frequent high stress level	Yes ☐ No ☐
Shortness of breath	Yes ☐ No ☐	Rash from topical antibiotics	Yes ☐ No ☐		
		Changing moles	Yes ☐ No ☐	**Immunologic/Heme**	
GI				Immunosuppressed	Yes ☐ No ☐
Ulcers	Yes ☐ No ☐				

PLEASE SIGN BELOW:

____ ______________________

Patient, Parent or Guardian Signature **Date**

R 02/15/2010