Peter Helton, D.O.
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(949) 646-3376

PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY)

Patient's Name:_____ SSN:_____

Street:_____ Date of Birth:_____ Age_____

City:_____State/Zip_____Home Phone:_____

Billing Address if different than above: Cell Phone: _____

Street:_____

City:_____State/Zip_____HomePhone:_____

Marital Status: M S D W Referred By:_____

Sex: M F Emergency Contact:_____ Phone Number:_____

Responsible Party:_____ SSN:_____

Street:_____ Date of Birth:_____ Age_____

City:_____State/Zip_____HomePhone:_____

Employer:_____ Work Phone:_____

Preferred Pharmacy Name & Location:_____.

Please give us your e-mail address if you would be interested in receiving our specials by e-mail: _____

Can confidential messages be left on your answering machine or voicemail? Y N

Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, and/or your payment operations:

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

PRIMARY INSURANCE	SECONDARY INSURANCE
Name:_____	**Name:**_____
Insurance Type: _____	**Insurance Type:** _____
Primary Name:_____	**Primary Name:**_____
Primary DOB:_____	**Primary DOB:**_____

Assignment of Benefits:
I assign all insurance benefits to **Dr.Peter Helton**. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Helton's office is **not responsible to know my plan, what it will pay for or the deductible requirements**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I hereby give my consent for examination, treatment and insurance billing.

Permission for Photography:
I hereby give permission to *Helton Skin and Laser Institute* to take necessary clinical photographs of me with the understanding that such photographs are for confidential, clinical record purposes and that all photographs remain the property of the doctor.

Internet Publishing:
I agree not to post electronic information about the doctor or *Helton Skin & Laser Institute* without the Doctor's written permission

Acknowledgment of Receipt of Notice of Privacy Practices:
I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature:_____**Date:**_____
Patient/Responsible Party

Print Name:_____

If not signed by the patient, please indicate:

Relationship:_____

Name of Patient:_____

Dermatology Medical History

Patient:_____ Date:_____
Reason for today's visit:_____
Are you allergic to any medications? ☐YES ☐NO If yes, list: _____
_____
Have you ever had a reaction to dental anesthesia (Lidocaine)? ☐YES ☐NO
List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and
herbals):_____
_____
Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis:	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Excessive thirst/hunger	☐	☐
Asthma	☐	☐	Thyroid	☐	☐
Shortness of breath	☐	☐	Kidney	☐	☐
Cardiovascular:	**YES**	**NO**	Bladder	☐	☐
Pacemaker `	☐	☐	Artificial joint	☐	☐
Inflammation of vein	☐	☐	Arthritis/joint deformity	☐	☐
High blood pressure	☐	☐	Nausea, vomiting, diarrhea		
Chest pain	☐	☐	when taking antibiotics	☐	☐
Heart attack	☐	☐	Convulsions, epilepsy		
Blood clots	☐	☐	seizures	☐	☐
Heart murmur	☐	☐			
Irregular heartbeat	☐	☐			

Skin:
When you are exposed to sun do you: ☐Tan only ☐Tan and burn ☐Burn
Have you ever had skin cancer: ☐YES ☐NO If yes, what kind?_____
_____
Do you have a history or any specific skin diseases? ☐YES ☐NO If yes, please list:_____
_____
Do you develop skin reactions to: ☐Medications ☐Food ☐Environment If yes, please explain:__
_____
List any other diseases or conditions:_____
List surgical procedures you have had in the last 6 months:_____
_____

Social History:
Do you drink alcohol? ☐YES ☐NO If yes, _____ drinks per day
Have you used IV drugs? ☐YES ☐NO
Do you smoke? ☐YES ☐NO If yes, how much?_____
Have you been exposed to HIV (AIDS)? ☐YES ☐NO

Please answer the following questions:
Do you bleed easily? ☐YES ☐NO
(Women) Are you pregnant? ☐YES ☐NO If yes, when is your due date?_____
What is your occupation?_____
What are your hobbies?_____
_____
Is there anything else you would like the Doctor to know?_____
_____