

DSCS Patient Registration
Patient Registration Information

DATE _____

PATIENT _____ Age _____ Date of Birth _____

Mailing Address _____ SSN _____ M or F

_____ Home Phone _____

Physical Address _____

Cell Phone _____ email: _____

Employer _____ Occupation _____

Work _____ Work _____

Address _____ Phone _____

SPOUSE _____ Date of Birth _____

Employer _____ Social Security No. _____

Work _____ Work _____

Address _____ Phone _____

GUARANTOR _____ **Relationship to Patient** _____

EMERGENCY CONTACT: _____ **Phone #** _____

**RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION,
FULL DISCLOSURE STATEMENT, AND AGREEMENT TO PAY FOR SERVICES**

I hereby authorize DSCS to release any information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of **LIFETIME**. I claim any insurance benefits due me for services rendered by DSCS and authorize and direct my carrier to issue payment check(s) directly to DSCS. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Patient Signature

DATE

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery	Thyroid Problems
Arthritis	Disease	Leukemia
Asthma	Depression	Lung Cancer
Atrial fibrillation	Diabetes	Lymphoma
Bone Marrow	End Stage Renal	Prostate Cancer
Transplantation	Disease	Radiation Treatment
Breast Cancer	GERD	Seizures
Colon Cancer	Hearing Loss	Stroke
COPD	Hepatitis	
	High Blood pressure	NONE
	HIV/AIDS	
	High Cholesterol	

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	NONE
Other _____	

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

NONE

Other _____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other _____

Family History (Only first degree relatives)

Preferred Language: _____

Race: _____ Ethnic Group: _____

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code: _____