DIBELLO PLASTIC SURGERY

PATIENT REGISTRATION FORM
(PLEASE PRINT CLEARLY)

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 ________________________________

*By entering your cell number, you agree to receive mobile messages at the phone number provided. Message frequency varies. Message and data rates may apply. You may see our Privacy Policy on our website at www.drdibello.com

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: ____**Date**: ______________

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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