Advanced Aesthetics
39 Pine Street New Canaan, CT 06840
Office (203) 972-7546
Fax (203) 972-5940

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name					**Salutation**
Date of Birth		**Age**		**SS #**	
Sex					
Address					
Town	**Zip Code**			**State**	

COMMUNICATION					
Preference					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Carrier**			
Email					

INFORMATION			
Race			
Marital Status			

ACCOUNT RESPONSIBLE (if patient is a minor)			
Responsible			
Relationship			

PRIMARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	

Emergency Contacts

First Name	Last Name	Relationship to Patient	Home #	Cell #

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RELEASE OF MEDICAL INFORMATION – STATUS		
Name of person we can speak to	**Relation to person we can speak to**	Release Status (may we leave messages? Speak to them? Etc.Indicate below)

Example: John Doe/Husband/ Can speak directly to him, and leave messages on machine at home.

PATIENT HEALTH HISTORY

Name:_____ DOB:_____

Reason for today's visit:_____

Do you have any alleriges?_____

Current
Medication(s)_____

Referring
Physician:_____

Current or past problems with;	Yes	No	If yes, explain
Asthma	_____	_____	_____
Arthritis	_____	_____	_____
Pacemaker/defibrilator	_____	_____	_____
High Blood Pressure	_____	_____	_____
Blood Clots	_____	_____	_____
Diabetes	_____	_____	_____
Joint Replacement	_____	_____	_____
Artificial Heart Valves	_____	_____	_____
Lupus	_____	_____	_____
Kidney Disease	_____	_____	_____
Skin Cancer	_____	_____	_____
Headache/Seizures	_____	_____	_____
Excessive Bleeding	_____	_____	_____
Blood/Bleeding Disorder	_____	_____	_____
Hepatitis	_____	_____	_____
Thyroid	_____	_____	_____

Females: are you pregnant? Yes No Females: planning to become pregnant? Yes No

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FAMILY HISTORY (PAST FAMILY & SOCIAL HISTORY

Mother: Living/Deceased _____ Age:_____ Father: Living/ Deceased:_____
Age:_____

(√) Check following medical condition(s) that have occurred in your family

Disease	Mother	Father	Blood Relative
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Hay Fever			
Heart Disease			
Squamous Cell Carcinoma			
Basal Cell Carcinoma			
Malignant Melanoma			
Psoriasis			
Tuberculosis			

SOCIAL HISTORY

Do you live alone? Yes No Do you smoke? Yes No

Do you drink alcohol? Yes No How frequently do you drink?

Hobbies/Leisure Acitivities:

Have you ever had a sunburn? Do you wear sunscreen daily?

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Do you use recreational drugs? Yes No How frequently do you use?

_____

Occupation:_____

Reviewed:_____ Date:_____ Update:_____
(MD Signature)