

Georgetown University Hospital, Department of Plastic Surgery
Patient Registration Forms

Patient	Name (Last, First MI): _____	MRN # _____	
	Address _____	Date of Birth: _____	Age: _____
	Day Phone: _____ Cell Phone: _____	Race: _____	M. Status: _____
	Employer: _____	Mother's Maiden Name: _____	
Address: _____	Occupation: _____ Phone: _____ Ext. _____		
Emergency Contact Name: _____	Next of Kin: _____		
Address: _____	Address: _____		
Relationship: _____ Phone: _____	Relationship: _____ Phone: _____		
Physician	Primary Care Physician: _____	Referring Physician: _____	
	Address: _____	Address: _____	
	Phone: _____ Fax: _____	Phone: _____ Fax: _____	
Guarantor	Guarantor Name (Bill To): _____	Guarantor Employer _____	
	Relationship to patient: _____	Address: _____	
	Address: _____	Phone: _____	
Insurance	Primary Insurance: _____	Secondary Insurance: _____	
	Address: _____	Address: _____	
	Subscriber Name: _____	Subscriber Name: _____	
	DOB: _____	DOB: _____	
	ID/Policy #: _____ Group #: _____	ID/Policy #: _____ Group #: _____	
Effective Date: _____	Effective Date: _____		

Worker's Comp: If work-related injury, please complete this section:

Employer: _____	Injury Date: _____	Case Number: _____
Case Worker / Contact Name / Phone Number: _____		
Insurance Carrier Name / Phone Number: _____		
Claims Address: _____		

Patient Name: _____

Date of Birth: _____

CURRENT HEALTH PROBLEMS

*** If you are currently taking medication for a specific medical problem, please indicate the medical problem below.*

1		4		7	
2		5		8	
3		6		9	

MEDICATIONS

[] No Current Medications

Please list medications you are currently taking (include prescriptions, over the counter medications, vitamins, and herbals); please include start dates, dosage, and frequency of each medication if known

1				7			
	Start Date:	Dosage:	Freq:		Start Date:	Dosage:	Freq:
2				8			
	Start Date:	Dosage:	Freq:		Start Date:	Dosage:	Freq:
3				9			
	Start Date:	Dosage:	Freq:		Start Date:	Dosage:	Freq:
4				10			
	Start Date:	Dosage:	Freq:		Start Date:	Dosage:	Freq:
5				11			
	Start Date:	Dosage:	Freq:		Start Date:	Dosage:	Freq:
6				12			
	Start Date:	Dosage:	Freq:		Start Date:	Dosage:	Freq:

*** Please let the receptionist know if you are taking more than 12 medications*

PHARMACY INFORMATION

Pharmacy Name:		Phone#:		Fax#:	
Address					

ALLERGIES

[] No Known Drug Allergies

1	Allergic to:	Reaction:
2	Allergic to:	Reaction:
3	Allergic to:	Reaction:
4	Allergic to:	Reaction:

Patient Name: _____

Date of Birth: _____

PAST MEDICAL HISTORY

Please check medical conditions you have had in the past and for which you are no longer taking medication. If you listed the condition above in "Current Health Problems," you do not need to check it here.

Alcohol / Drug Abuse	Circulation Probs / PAD	Heart Attack	Lung Disease	Scleroderma
Anemia	Cirrhosis	Heart Disease	Lupus	Seizure Disorder
Anesthesia Problems	Clotting Tendency	Heart Murmur	Mental Illness	Skin Cancer
Anxiety	Chrohn's Disease	Hepatitis	Neurologic Disease	Stroke
Asthma	Deep Vein Thrombosis	High Cholesterol	Organ Transplant	Thyroid Disease
Back Problems	Depression	Hypertension	Other Cancer	TIA
Bleeding Tendency	Diabetes	Hypotension	Paraplegia/Quadriplegia	Use of Steroids
Breast Cancer	Eye Problems	Kidney Disease	Pulmonary Embolism	Venous Stasis
Central Venous Access	GERD	Liver Disease	Reynaud's Disease	Varicose Veins
OTHER:	1	2	3	4

PAST SURGICAL HISTORY

NO PAST SURGICAL HISTORY

Abdominal Surgery	Breast Lift	Face Lift	Hx of Surgical Comp	Nerve Surgery
Abdominoplasty	Breast Recon	Facial Surgery	Hysterectomy	Otoplasty
Adenoidectomy	Breast Reduction	Flap Surgery	Jaw Surgery	Rhinoplasty
Alveolar Bone Graft	Brow Lift	Fracture Repair	Lap Band Surgery	Septoplasty
Amputation	CABG	Gallbladder	Liposuction	Thyroidectomy
Appendectomy	Cesarean Section	Gastric Bypass Surgery	Lumpectomy	Tonsillectomy
Blepharoplasty	Cleft Lip Repair	Genioplasty	Mastectomy (Lt/Rt)	Tubal Ligation
Breast Augmentation	Cleft Palate Repair	GYN Surgery	MOHS Surgery	Vision Corr Surgery
Breast Biopsy	Cosmetic Surgery	Hernia Repair	Neck Lift	Wisdom Tooth Removal
OTHER:	1	2	3	4

FAMILY HISTORY

Skin Cancer	Diabetes	Stroke	Breast Cancer
Heart Disease	Bleeding Tendency	Other Cancer	Peripheral Neuropathy
OTHER:	1	2	3

SOCIAL HISTORY

# of Children:	Education:	
Smoking Status: [] No [] Yes [] Former	Packs/Day: #	Quit Date:
Alcohol: [] None [] Rare [] Occasionally [] Frequently		

I have reviewed and/or updated the above information and confirmed it as accurate.

Patient Signature _____ Date: _____