Georgetown University Hospital
MedStar Health

Georgetown University Hospital, Department of Plastic Surgery
Patient Registration Forms

Patient

Name (Last, First MI): _____ **MRN #** _____

Address _____ Date of Birth: _____ Age: _____

Race: _____ Ethnicity: _____

Day Phone: _____ Cell Phone: _____ Marital Status: _____

Email: _____ Mother's Maiden Name: _____

Employer: _____

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: _____ 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 _____ 4 _____

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:** _____