Peter Helton, D.O.
1901 Westcliff Dr. Suite #2, Newport Beach, CA 92660
(949) 646-3376

PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY)

Patient's Name:_________________________________ SSN:____________________

Street:________________________________ Date of Birth:___________ Age______

City:_________________State/Zip________________Home Phone:_________________

Billing Address if different than above: Cell Phone: ________________

Street:________________________________

City:_________________State/ Zip________________HomePhone:_________________

Marital Status: M S D W Referred By:______________________________

Sex: M F Emergency Contact:_________________ Phone Number:____________

Responsible Party:_______________________________ SSN:____________________

Street:________________________________ Date of Birth:___________ Age______

City:_________________State/

Zip________________HomePhone:_________________

Employer:______________________________ Work Phone:_______________________

Preferred Pharmacy Name & Location:

Please give us your e-mail address if you would be interested in receiving our specials by e-mail: ____

Can confidential messages be left on your answering machine or voicemail? Y N

Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, and/or your payment operations:

Name:__________________________________ Phone Number:_____________________

Name:__________________________________ Phone Number:_____________________

PRIMARY INSURANCE	SECONDARY INSURANCE
Name:___________________________	
Name:________________________________	
Insurance Type: ____________________	**Insurance Type:** ____________________
Primary Name:____________________	**Primary Name:**__________
Primary DOB:___________________	**Primary DOB:**_____________

Assignment of Benefits:
I assign all insurance benefits to **Dr. Peter Helton**. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Helton's office is **not responsible to know my plan, what it will pay for or the deductible requirements**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I hereby give my consent for examination, treatment and insurance billing.

Permission for Photography:
I hereby give permission to Helton Skin and Laser Institute to take necessary clinical photographs of me with the understanding that such photographs are for confidential, clinical record purposes and that all photographs remain the property of the doctor.

Internet Publishing:
I agree not to post electronic information about the doctor or Helton Skin & Laser Institute without the Doctor's written permission

Acknowledgment of Receipt of Notice of Privacy Practices:
I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature:____**Date:**_________________
Patient/Responsible Party

Print Name:____

If not signed by the patient, please indicate:

Relationship:____

Name of Patient:____

Dermatology Medical History

Patient:____ Date:_________________________

Reason for today's visit:____

Are you allergic to any medications? ▫YES ▫NO If yes, list: ____________________________

____

Have you ever had a reaction to dental anesthesia (Lidocaine)? ▫YES ▫NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals):____

____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis:	▫	▫	Diabetes	▫	▫
Emphysema	▫	▫	Excessive thirst/hunger	▫	▫
Asthma	▫	▫	Thyroid	▫	▫
Shortness of breath	▫	▫	Kidney	▫	▫
Cardiovascular:	**YES**	**NO**	Bladder	▫	▫
Pacemaker `	▫	▫	Artificial joint	▫	▫
Inflammation of vein	▫	▫	Arthritis/joint deformity	▫	▫
High blood pressure	▫	▫	Nausea, vomiting, diarrhea		
Chest pain	▫	▫	when taking antibiotics	▫	▫
Heart attack	▫	▫	Convulsions, epilepsy		
Blood clots	▫	▫	seizures	▫	▫
Heart murmur	▫	▫			
Irregular heartbeat	▫	▫			

Skin:

When you are exposed to sun do you: ▫Tan only ▫Tan and burn ▫Burn

Have you ever had skin cancer: ▫YES ▫NO If yes, what kind?_____________________________

____

Do you have a history or any specific skin diseases? ▫YES ▫NO If yes, please list:____________

____

Do you develop skin reactions to: ▫Medications ▫Food ▫Environment If yes, please explain:__

____

List any other diseases or conditions:____

List surgical procedures you have had in the last 6 months:_______________________________

____

Social History:

Do you drink alcohol? ▫YES ▫NO If yes, ________ drinks per day

Have you used IV drugs? ▫YES ▫NO

Do you smoke? ▫YES ▫NO If yes, how much?_______________________________________

Have you been exposed to HIV (AIDS)? ▫YES ▫NO

Please answer the following questions:

Do you bleed easily? ▫YES ▫NO

(Women) Are you pregnant? ▫YES ▫NO If yes, when is your due date?___________________

What is your occupation?____

What are your hobbies?____

____

Is there anything else you would like the Doctor to know?_________________________________

____