REGISTRATION DATA **Allison Jones Stocker, M.D.,P.A. /// Skin by Design Dermatology & Laser Center, P.A**

********PRINT CLEARLY ********

Name____ Sex: M F
last **first** **middle**

Address____Zip_________
City **State**

Age________Date of Birth________/_________/___________ Marital Status________ Home # (_________)_______________________

RECEIVE SMS MESSAGES Yes / No Cell # (_________)______________________________

Occupation______________________________Employer's Name____

ATTACH: Driver's License: PROVIDED ❑ Work # (_________)______________________________

EMAIL ADDRESS PROVIDED FOR APPOINTMENT CONFIRMATION AND PRACTICE UPDATES

EMAIL ADDRESS:____

If Minor, Name of Parent/Guardian_______________________________________Relationship___________________

In an emergency contact_______________________________________Phone_______________Relationship_________

List medications and dosage which you are taking or take **regularly** (including over-the-counter, herbal & vitamins)

____Over

List **other** medications which you take **occasionally**: ❑ See list - attached

____ Over

Allergies to medications: yes no List:____Over

Check (√) the conditions which ***you*** have had:

- ____ Arthritis (type)________________________
- ____ Asthma/Allergies
- ____ Blood Clots (where)____________________
- ____ Cancer (of which organ)_______________
- ____ Diabetes
- ____ Glaucoma
- ____ Heart disease
- ____ Heart valve disease
- ____ Pacemaker
- ____ High Blood Pressure
- ____ Hepatitis type A B C
- ____ HIV Infection
- ____ Tuberculosis
- ____ Skin Cancer (where)________________(type)______________
- ____ Skin issues, please specify ____________________________
- ____ Ulcers (where)______________________________________
- Other____

Check (√) the conditions which your ***blood relatives*** have had:

- ____Asthma/Allergies
- ____Diabetes
- ____High Blood Pressure
- ____Skin Cancer (where)_________________ (type)_________________
- ____Skin issues, please specify ___________________________________
- Other____

Family physician name:____Referred by_______________________________________

Please read & sign below:

1 I understand that I am responsible for payment of all services provided by the physician and/or Skin by Design and that the entire bill for all services is due at completion of each individual appointment. 2 I authorize this office to release any and all records pertaining to me for any diagnosis and treatment received today or subsequently to my physician(s). 3 <u>I agree that if I cancel any appointment I will give a 48 hour advance notice or there will be a $100.00 fee for non-cancellation.</u> 4 Payments made by check-I authorize the use of information provided to process transactions. Withdrawal from my account may be as soon as the same day I make payment. I understand if the check is returned there will be an additional $75 charge.

X____ Date_________________
Signature(Patient/Guardian)