STUART LIPTON, M.D.

PATIENT REGISTRATION FORM

Today's Date _____ E-Mail Address _____

_____
First Name Middle Initial Last Name

_____
Address

_____
City State Zip

_____
Home Phone # Other Phone #: [ ] Work [ ] Cell [ ] Other

_____
Date of Birth Social Security # Driver's License #

Marital Status: [ ] Single [ ] Married [ ] Other Sex: [ ] Female [ ] Male

Work Status: [ ] Employed [ ] Retired [ ] Student [ ] Other

_____
Occupation Employer

_____
Emergency Contact Person Relationship Phone #

_____
Reason for your appointment today

Referred by: _____

Medical History

Is your health: Good [ ] Fair [ ] Poor [ ]

If not good, please explain:

_____

Weight_____ Height_____ Age _____

Have you gained/lost weight this year? Gained _____ Lost _____
Due to?_____

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When was your last:

Physical check-up _____
Chest X-Ray _____
EKG _____
Mammogram _____

What is your daily consumption of the following:

Tobacco _____
Alcoholic Bev. _____

PLEASE LIST ALL DRUG ALLERGIES: _____

PLEASE LIST **ALL** DRUGS YOU ARE CURRENTLY TAKING/THIS INCLUDES PRESCRIPTION, OVER THE COUNTER/HEALTH STORE OR NATURAL SUPPLEMENTS:

_____
_____
_____

PLEASE LIST **ALL** SURGERIES YOU'VE HAD:

Operation: Year Surgeon General or local anesthesia

_____
_____
_____
_____

Name of Internist or Family Physician: _____
Physician Telephone Number:_____
Did you have any complications from surgery/anesthesia?

_____

Does or did any close family relative have:

Cancer	_____	High Blood Pressure	_____
Diabetes	_____	Lung Disease	_____
Kidney Disease	_____	Blood or bleeding disorders	_____
Asthma	_____	Tuberculosis	_____
Scarlet Fever	_____	Rheumatic Fever	_____
Skin Diseases	_____	Heal Poorly	_____
Scar Easily	_____	Shortness of Breath	_____

Other: _____

Do you have any of these?_____
_____
_____

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Insurance Information

Primary Insurance Company Insurance Company Phone #

Member ID# Group#

Insured Social Security # Date of Birth

Insured's Employer Employer Phone #

Secondary Insurance Company Insurance Company Phone #

Member ID# Group#

Insured Social Security # Date of Birth

Insured's Employer Employer Phone #

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances of percentages based on your contract with them not with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance company. We will assist you in receiving reimbursement as much as possible, but you are responsible for you bill.

I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION/RECORDS NECESSARY TO PROCESS MY CLAIMS AND THAT IS PERTINENT TO MY MEDICAL CARE. I ASSIGN ALL MEDICAL BENEFITS TO DR. STUART LIPTON. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES AND HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Patient or Responsible Party Signature Relationship to patient Date

PLEASE PRESENT A VALID DRIVER'S LICENSE & INSURANCE CARD TO RECEPTIONIST