

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**

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**Primary Insurance Company** Insurance Company Phone #

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Member ID# Group#

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Insured Social Security # Date of Birth

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Insured's Employer Employer Phone #

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**Secondary Insurance Company** Insurance Company Phone #

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Member ID# Group#

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Insured Social Security # Date of Birth

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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.

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Patient or Responsible Party Signature Relationship to patient Date  
PLEASE PRESENT A VALID DRIVER'S LICENSE & INSURANCE CARD TO RECEPTIONIST