

# REGISTRATION

(PLEASE PRINT)

# CONGRESS COSMETIC MEDICAL CORP.

10 Congress, #320  
Pasadena, CA 91105

Telephone: (626) 585-9474

**DOCTOR IS NOT A PROVIDER  
FOR ANY INSURANCE**

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Call Phone (\_\_\_\_) \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_  
Last Name First Name Middle Initial  
Address \_\_\_\_\_ E-mail \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)  
Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand  
that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.  
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and  
their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This  
consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

# Health History

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Reason for visit \_\_\_\_\_

*Conditions - Please check (✓) conditions you currently had or have had in the past year.*

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Keloids            | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Sinus Problems     |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Skin Cancer        |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Fever Blisters   | <input type="checkbox"/> Melanoma           | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Gonorrhea        | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Rashes             | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio              |   |
| <input type="checkbox"/> Cold Sores          | <input type="checkbox"/> Hives            | <input type="checkbox"/> Psoriasis          |   |

### Social History

*Please indicate how often*

- |                                   |       |
|-----------------------------------|-------|
| <input type="checkbox"/> Caffeine | _____ |
| <input type="checkbox"/> Drugs    | _____ |
| <input type="checkbox"/> Tobacco  | _____ |
| <input type="checkbox"/> Alcohol  | _____ |

*Are you currently suffering from any of these symptoms?*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Change in moles | <input type="checkbox"/> Sore that won't heal |
| <input type="checkbox"/> Hives         | <input type="checkbox"/> Rash            |   |
| <input type="checkbox"/> Itching       | <input type="checkbox"/> Scars           |   |

<i>Hospitalizations</i>			<i>Serious Illness/Injury</i>	
<i>Year</i>	<i>Hospital</i>	<i>Reason</i>	<i>Date</i>	<i>Outcome</i>

### *Medications*

*List all medications you are currently taking*

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### *Allergies*

*Food and drug Allergies*

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Pharmacy Name \_\_\_\_\_ Phone Number \_\_\_\_\_

I certify that the above information is true and correct. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian signature required if patient is a minor) (Include relationship to patient if he/she is a minor)

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# **PRIVACY PRACTICES ACKNOWLEDGEMENT**

## **ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_