4340 Sheridan St.
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Sobel and Sofman, M.D., P.A.
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Date________________________

Registration Form (please print)

Name ______________________________________ Street Address ____

City ______________________________ Zip ___________ Phone _______________________ Cell ____________________

E-mail address ____

If applicable, out of state address ____ City______________________

State _______ Zip ___________ Out of State Phone ____________________ Dates: from ____________ to _____________

DOB________________ Gender ___ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race ☐ White ☐ Black/Afr. Am. ☐ Asian ☐ Native American/Alaskan ☐ Hawaiian/Pac. Islander ☐ Mixed

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic Primary Language______________________________________

Social Security # ____

Occupation ________________________ Employer __________________________ Bus. Phone _______________________

Employer's address _______________________________________ City _________________ State________ Zip __________

Name of spouse or parent ___________________________________ Telephone (if different than above) ________________

Address (if different than above) ____

Person responsible for payment __________________________ Address (if different)_________________________________

Primary Insurance____ Policy #______________________________

Policyholder________________________________ Policyholder's date of birth ______________________

Policyholder's Social Security # ___________________________________

Secondary Insurance_______________________________________ Policy #______________________________

Policyholder________________________________ Policyholder's date of birth _____________________

Preferred Pharmacy ______________________________

Location (address or intersection) ____

Phone ____

Emergency contact ________________________ Phone ____________________ Relationship__________________

Referred by ____

Thank you!

SOBEL & SOFMAN, M.D., P.A.
HEALTH QUESTIONNAIRE

Name____ Age________ Date__________________
Address____________________________________ City______________________ State_______
Phone ______________________________ Cell Phone___________________________________
Who referred you to our office?____
The reason for your visit____
____

Medical History- Please check if you have (had) any of the following:

- ☐ Asthma
- ☐ Hay fever
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Angina
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Irregular heartbeat
- ☐ Pacemaker/defibrillator
- ☐ Congestive heart failure
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Glaucoma
- ☐ Anemia
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Seizures
- ☐ Arthritis
- ☐ Gout
- ☐ Tuberculosis
- ☐ Psychiatric disease
- ☐ Migraines
- ☐ Varicose veins
- ☐ Prostate disease
- ☐ Blood transfusions
- ☐ Other _________________

Further explanation if necessary____
____

Surgical History- please list the surgeries you've had:

Year	Type

Medications- please list your current medications, including oral contraceptives and over-the-counters:

____
____
____
____

Allergies:

To Medications		To Foods	To Environment
Name	**Type of Reaction**		

Family History- please list other family members with any of the following:

Asthma____

Eczema____

Severe allergies______________________________________

Hay fever____

Psoriasis____

Acne____

Melanoma____

Other skin cancers____________________________________

Irregular moles_______________________________________

Hair loss____

Diabetes____

Cancer____

Social History:

Occupation:________________________ Hobbies:_____________________________

Where are you originally from?___________________ Pets _________________________

Smoking: ____ packs/day for _____ years Do you currently smoke? ☐ Yes ☐ No

Alcohol ____

Skin History- please check if you have (had) any of the following:

☐ Acne	☐ Pre-cancerous growths	☐ Hair transplants
☐ Eczema	☐ Irregular moles	☐ Fillers
☐ Psoriasis	☐ Hair loss	☐ Laser surgery
☐ Ringworm	☐ Shingles	☐ Plastic surgery
☐ Athlete's foot	☐ Fever blisters	☐ Liposuction
☐ Skin cancer	☐ Herpes	☐ Varicose veins
☐ Melanoma	☐ Dermabrasion	☐ Excessive bleeding
☐ Warts	☐ Facial peels	☐ Poor wound healing
☐ Keloids or excessive scarring	☐ Botox	☐ Other __________

Sun History

Have you had any blistering sunburns? ______________________________

Do (did) you work outdoors? ______________________________________

Do (did) you spend much leisure time outdoors? ______________________

Do you go to tanning parlors? _____________________________________

Do you use sunscreen? ____

When you are out in the sun, do you (check one)

☐ Always burn, never tan	☐ Burn easily, tan minimally	☐ Burn moderately, tan lightly
☐ Rarely burn, tan darkly	☐ Never burn, always tan	

Is there any other significant medical history not covered above?

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Sobel and Sofman, M.D., P.A.
RELEASE FORM

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of **Sobel and Sofman, M.D., P.A.'s**
Patient Name

Notice of Privacy Practices.

______________________________ ____________________
Signature of Patient or Personal Representative Date

____
Name and Relationship of Personal Representative

PATIENT'S SIGNATURE RELEASE AUTHORIZATION AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize use of this form on all my insurance submissions. I understand that **I am financially responsible** for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. I authorize payment directly to **Sobel and Sofman, M.D., P.A.**

______________________________ ____________________
Signature of Patient or Personal Representative Date

______________________________ ______________________________
Patient's name Name and Relationship of Personal Representative

PATIENT'S RELEASE TO VIEW MEDICATION HISTORY

One of the features of electronic prescribing systems is that it allows us to view medications that have been electronically prescribed to you by other physicians. This improves patient safety by helping us avoid prescribing medications that might interfere with what you are already taking. By signing below, you authorize us to view your medication history.

______________________________ ____________________
Signature of Patient or Personal Representative Date

______________________________ ______________________________
Patient's name Name and Relationship of Personal Representative