DRS. KOSLIN & KAHN, P.C.
REGISTRATION FORM

PATIENT NAME_____ AGE_____ DATE OF BIRTH_____ MALE___ FEMALE___

HAVE YOU EVER BEEN A PATIENT OF OURS BEFORE? Y / N HAS ANYONE IN YOUR FAMILY BEEN A PATIENT OF OURS BEFORE? Y / N

PATIENT SOCIAL SECURITY #_____ SINGLE MARRIED WIDOWED DIVORCED FULL TIME STUDENT? Y / N

HOME ADDRESS_____ CITY/STATE_____ ZIP_____

EMPLOYER_____ HOME PHONE_____OFFICE PHONE_____

OFFICE ADDRESS_____ CITY/STATE_____ ZIP_____

FAMILY DENTIST_____ FAMILY PHYSICIAN_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

NAME OF NEAREST RELATIVE NOT LIVING W/YOU?_____ RELATIONSHIP_____

ADDRESS_____ CITY/STATE/ZIP _____PHONE_____

RESPONSIBLE PARTY INFORMATION

WHO IS RESPONSIBLE FOR CHARGES? MYSELF SPOUSE MOTHER FATHER

PERSON RESPONSIBLE_____ SOCIAL SECURITY #_____

HOME ADDRESS_____ HOME PHONE_____

EMPLOYER_____ OFFICE PHONE_____

OFFICE ADDRESS_____ CITY/ST_____ ZIP_____

SPOUSE/OTHER PARENT NAME_____ SOCIAL SECURITY #_____

HOME ADDRESS_____ HOME PHONE_____

EMPLOYER_____ OFFICE PHONE_____

OFFICE ADDRESS_____CITY/ST_____ ZIP_____

ALL FEES ARE DUE AT THE TIME OF SERVICE UNLESS OTHERWISE DISCUSSED

METHOD OF PAYMENT: CHECK CASH VISA MASTERCARD AMEX DISCOVER

I AM COVERED UNDER THE FOLLOWING INSURANCE POLICIES:

MEDICAL INSURANCE CARRIER_____

NAME OF INSURED_____ DATE OF BIRTH_____

CONTRACT # _____ GROUP # _____ MALE___ FEMALE___

MEDICAL INSURANCE CARRIER_____

NAME OF INSURED_____ DATE OF BIRTH_____

CONTRACT # _____ GROUP # _____ MALE___ FEMALE___

DENTAL INSURANCE CARRIER_____

NAME OF INSURED_____ DATE OF BIRTH_____

CONTRACT # _____ GROUP # _____ MALE___ FEMALE___

DENTAL INSURANCE CARRIER_____

NAME OF INSURED_____ DATE OF BIRTH_____

CONTRACT # _____ GROUP # _____ MALE___ FEMALE___

I hereby authorize the release of any medical information and assign all insurance benefits to the doctors. I understand that I am financially responsible to the doctors for all of my family's individual charges incurred during the course of my treatment. Even though I may have insurance or other third party coverage. I promise to pay this amount when due. In event of default and this account is placed with a 3rd party collection agency, I agree to pay add on collection charges in the amount of 33.33% of the unpaid balance. In the event of default, I recognize that legal proceedings may result and I agree to pay all costs of collection, including reasonable attorney's fees. I understand that certain insurance carriers and health organizations require referral from the designated primary care doctor prior to being seen by a specialist. It is the patient's responsibility to secure this authorization. It is understood that if the referral was not secured or not approved that the patient is responsible for all charges. Any charges rejected as non-covered are also the responsibility of the patient.

SIGNATURE OF RESPONSIBLE PARTY TODAY'S DATE

KOSLIN & KAHN, P.C.

HEALTH HISTORY

Please fill out completely.

Circle any of the following that you have now or have had in the past:

HEART FAILURE	CHRONIC COUGH	BRUISE EASILY	HEMOPHILIA
HEART DISEASE	TUBERCULOSIS	ASTHMA	PNEUMONIA
HEART ATTACK	THYROID DISEASE	HEPATITIS	LIVER DISEASE
HEART MURMUR	HIGH BLOOD PRESSURE	DIABETES	KIDNEY STONES
SCARLET FEVER	EMPHYSEMA	EPILEPSY	SEIZURES
BALLOON ANGIOPLASTY	GLAUCOMA	HIV OR AIDS	STROKE
OPEN HEART SURGERY	SINUS PROBLEMS	CHRONIC BRONCHITIS	ANEMIA
HEART PACEMAKER	MITRAL VALVE PROLAPSE	FAINTING	ULCERS

Are you under the care of a physician? YES_____ NO_____

For what purpose? _____

Physician's name _____

Have you been hospitalized in the last five years? YES _____ NO_____

For what reason? _____

Do you smoke? YES _____ NO _____

Circle any medication to which you are allergic or have had an adverse reaction:

ASPIRIN	NITROUS OXIDE	VALIUM	LORCET	ERYTHROMYCIN	SULFA
MOTRIN	LOCAL ANESTHESIA	KELFLEX	PERCODAN	TETRACYCLINE	PENICILLIN
DARVOCET	ANTI-INFLAMMATORIES	CODEINE	LORTAB	DEMEROL	PHENERGAN

PLEASE LIST ALL MEDICINES THAT YOU TAKE:

_____

_____

_____

Circle any operations that you have had:

HEART SURGERY	HERNIA SURGERY	GUM SURGERY	BREAST SURGERY
HYSTERECTOMY	JOINT REPLACEMENT	TMJ SURGERY	NASAL SURGERY
TUBAL LIGATION	BONE SURGERY	JAW SURGERY	WISDOM TEETH REMOVED
GALL BLADDER	EAR SURGERY	VASCULAR SURGERY	TONSILLECTOMY
BACK SURGERY	OTHER: _____		

PLEASE LIST ANY PROBLEMS YOU HAVE WITH ANESTHETIC MEDICINES:

_____

_____

******FOR WOMEN ONLY: ARE YOU PREGNANT ? YES_____ DUE DATE ?_____ NO_____*

_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: (_____) _____

PATIENT SIGNATURE _____ DATE _____

PARENT OR RESPONSIBLE PARTY _____

KKHH/LM1005