

CHERYL S. CITRON, M.D., F.A.A.D.
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DATE _____ FAMILY OR REFERRING DR. _____	
NAME _____	AGE _____ BIRTH DATE ____/____/____
ADDRESS _____	CITY _____ STATE _____ ZIP _____
E-mail _____ <i>I give permission to receive promotional mailings and offerings by this office only.</i>	
PATIENT S.S.# _____	PHONE _____ MOBILE _____
SEX M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS / S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>
PATIENT EMPLOYER & ADDRESS _____	
EMPLOYER PHONE _____	OCCUPATION _____
REFERRED BY WHOM: _____	
SPOUSE OR NEAREST RELATIVE _____	PHONE _____
ADDRESS _____	RELATIONSHIP _____
REASON FOR VISIT _____	

RESPONSIBLE PERSON NAME _____	S.S. # _____
ADDRESS _____	
PHONE (H) _____	(W) _____ RELATIONSHIP _____
EMPLOYER & ADDRESS _____	

INSURANCE INFORMATION

PRIMARY CARRIER _____	SUBSCRIBER _____	DATE OF BIRTH _____
ADDRESS _____		
POLICY # _____	GROUP # _____	PLAN _____
SECONDARY CARRIER _____	SUBSCRIBER _____	DATE OF BIRTH _____
ADDRESS _____		
POLICY # _____	GROUP # _____	PLAN _____

I authorize the release of my healthcare information for treatment, payment or healthcare operational purposes. Although this office will assist in filing claims, I understand that I am financially responsible for all fees incurred. All surgery and cosmetic services must be cancelled 24 hours in advance to avoid any charge.

Signature _____ **Date** _____

MEDICAL HISTORY

NAME _____ WEIGHT _____ HEIGHT _____

SURGERY (OPERATIONS):

TYPE	DATE	COMPLICATIONS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

ADMISSIONS TO HOSPITAL:

REASON	DATE	COMPLICATIONS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

MEDICATIONS (ANY DRUG, MEDICATION, HERBAL MEDICATION) YOU TAKE NOW:

TYPE	DOSAGE	TAKEN HOW OFTEN?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

CONSUMPTION OF THE FOLLOWING:

ASPIRIN _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____
ALCOHOL _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____
TOBACCO _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____

BLEEDING PROBLEMS (WITH CUTS, TOOTH EXTRACTIONS, PREGNANCY, SURGERY?)

EXPLAIN:

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:

EXPLAIN:

MEDICAL PROBLEMS OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:

EXPLAIN:

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

NAME _____ DATE _____

DO YOU HAVE ALLERGIES TO THE FOLLOWING ?

	YES	NO	DESCRIBE REACTION
PENICILLIN?	<input type="checkbox"/>	<input type="checkbox"/>	_____
ERYTHROMYCIN?	<input type="checkbox"/>	<input type="checkbox"/>	_____
SULFA?	<input type="checkbox"/>	<input type="checkbox"/>	_____
IODINE ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
CONTACT ALLERGY?	<input type="checkbox"/>	<input type="checkbox"/>	_____
TAPE?	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER?	<input type="checkbox"/>	<input type="checkbox"/>	_____

LATEX _____
 EXPLAIN ALLERGIC EFFECTS: _____

DATE OF LAST TETANUS SHOT: _____

ILLNESSES & MEDICAL PROBLEMS:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	PRIOR STEROID THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ANESTHESIA PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER EYE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DIVERTICULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	EAR TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	BOWEL PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	DEAF, HEARING-IMPAIRED	<input type="checkbox"/>	<input type="checkbox"/>	MONONUCLEOSIS
<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	GALLBLADDER TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	NASAL FRACTURE	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS, SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	SWELLING IN NECK	<input type="checkbox"/>	<input type="checkbox"/>	SCARLET FEVER
<input type="checkbox"/>	<input type="checkbox"/>	HEALING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY / BLADDER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HERNIAS	<input type="checkbox"/>	<input type="checkbox"/>	VARICOSE VEINS
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	SPIDER VEINS
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	<input type="checkbox"/>	LUPUS, AUTOIMMUNE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ANKLE SWELLING
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL / NEUROLOGICAL CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY			
<input type="checkbox"/>	<input type="checkbox"/>	SKIN CANCER (BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA OR MELANOMA)			

PRECANCEROUS LESIONS (ACTINIC KERATOSIS, ATYPICAL DYSPLASTIC NEVUS)

CANCER year/type

WOMEN:

<input type="checkbox"/>	<input type="checkbox"/>	TENDER BREASTS	LAST MAMMOGRAM YEAR _____
<input type="checkbox"/>	<input type="checkbox"/>	FIBROCYSTIC BREASTS	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
<input type="checkbox"/>	<input type="checkbox"/>	MENSTRUAL PROBLEM	LAST MENSTRUAL PERIOD _____
<input type="checkbox"/>	<input type="checkbox"/>	WERE YOUR CHILDREN BREAST FED?	NUMBER OF CHILDREN _____
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU PLAN TO HAVE CHILDREN	DO YOU TAKE HORMONES OR BIRTH CONTROL PILLS?
<input type="checkbox"/>	<input type="checkbox"/>	BREAST LUMPS	<input type="checkbox"/> YES <input type="checkbox"/> NO

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**HEALTH INSURANCE PATIENT ACCOUNTABILITY ACT
(HIPPA)**

Drs. Citron, Citron and Speaker have always supported and recognized our patients' rights to expect that their medical records and other information about their care be kept confidential. The HIPPA privacy use and release of medical records, establish appropriate safeguards that all health care providers must achieve to protect the privacy of health information. They hold violators accountable with civil and criminal penalties if they violate patients' privacy rights.

One of the provisions of the HIPPA privacy regulations is that all health care providers distribute a "Notify of Privacy Practices". All patients can read this notice displayed in our waiting room. You are not required to read this notice, however, we are asking that you acknowledge having received access to this displayed notice by signing this acknowledgment statement.

Signature _____ Date _____