McClerklin Skin & Laser Center

Patricia A. McClerklin, M.D., P.A.

Name _____ **SSN#:** _____

PATIENT REGISTRATION

PERSONAL INFORMATION			
Name		SSN#:	
Street Address		Date of birth	Marital Status S M W Sep D
City		State	Zip
Tele # (Home)	Cell #	Office #	
Referred by		Relationship	
Spouse Name		Spouse Tele#	
Spouse Employer /Address			
Emergency Contact Name		Emergency Contact Tele#	
Emergency Contact Relationship			

INSURED PATIENT/PARENTAL INFORMATION			
Patient is a minor? Y / N		Relationship:	
Parent/Guardian/Insured #1 Name		SSN#:	
Parent/Guardian/Insured #2 Name		SSN#:	
Street Address			
City		State	Zip
Tele # (Home)	Cell #	Office #	

PATIENT EMPLOYER INFORMATION	
Employer Name:	Tel #:
Employer Street Address	
Patient's Occupation	

INSURANCE		
Medicaid # (if applicable):	Medicare # (if applicable):	
Primary Insurance Company Name:		
ID #:	Group #:	Tele #:
Secondary Insurance Company Name:		
ID #:	Group #:	Tele #:

MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ **Signature:** _____

I hereby authorize Dr. McClerklin to apply for benefits on my behalf for covered services rendered by her or by her provider. I request that payment from my insurance company be made directly to Dr. McClerklin (or to the party who accepts this assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by my insurance company at any time in writing.

Date: _____ **Signature:** _____
(Patient, Parent, or Guardian)

112 Doctors Circle * Columbia, S.C. 29203 * (803) 771-9163
1585 Carolina Avenue * Orangeburg, S.C. 29115 * (803) 534-3890 * Fax (803) 771-7383
191 Centre South * Aiken, S.C. 29803 * (803) 649-6740 * Fax (803) 649-6749

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GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy, or nursing a child? □ Yes □ No No. of years _____

Do you smoke? □ No □ Yes □ Pipe □ Cigars No. of years How much? _____

Are you interested in stopping? □ Yes □ No

Do you regularly drink alcohol? □ Yes □ No How many ounces/beers per day? _____

Do you regularly drink coffee? □ Yes □ No How many cups per day? _____

Are you under a lot of pressure at work? □ Yes □ No Please describe _____

PERSONAL MEDICAL HISTORY

Have you ever had one of the following (check all that apply):

- □ Chest Pain/pressure/tightening
- □ Hypertension
- □ Heart attack
- □ Stroke
- □ Headaches
- □ Glaucoma
- □ Allergies or Eczema
- □ Depression
- □ Blood in stool
- □ Asthma
- □ Dizzy spells
- □ Cancer
- □ Diabetes
- □ Arthritis
- □ Difficulty hearing
- □ Anemia
- □ Memory loss
- □ Hemorrhoids
- □ Herpes/cold sores
- □ Kidney disease
- □ Shortness of breath
- □ TB/Lung disorder
- □ Ulcers
- □ Skin disorders
- □ Hepatitis
- □ Cataracts
- □ Digestive problems
- □ Frequent urinary infections

Hepatitis C risk factor

- □ Blood transfusion prior to 1992
- □ IV drug use (1+ times)
- □ Contact with daily blood/bodily fluid
- □ Tattoos
- □ Shared razor/toothbrush
- □ Body piercing

Other risk factors

Are you HIV positive? Yes No If so, when were you diagnosed? _____

Have you been diagnosed with AIDS? Yes No

IMMUNIZATIONS (Years last received, if known)
Smallpox
Tetanus
Typhoid
Polio
Influenza
Pneumonia
Rubella
Hepatitis
Hay Fever

FAMILY HISTORY *(Please place a check mark in the appropriate box)*

	Father	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
High Blood Pressure						
Epilepsy						
Cancer						
Eczema/Psoriasis						
Heart attack/Stroke						
Diabetes						
Asthma						
Hay fever						

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