Miracle Mile Medical Center for Dermatology and Cosmetic Surgery, Inc.
Samer Alaiti, M.D. FACP
6200 Wilshire Blvd Suite 1502
Phone #: (323) 938-2626 Los Angeles, CA 90048 Fax #: (323) 938-2493

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

NAME	MARITAL STATUS S M W D SEP	DATE OF BIRTH	DATE
STREET ADDRESS		CITY STATE, ZIP	
PHONE # - HOME ( )	WORK # ( )	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE # ( )
IF UNDER 18 **PARENT / GUARDIAN**			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE # ( )	ADDRESS	RELATION
S.S. #	DRIVER'S LICENSE #	REFERRED BY	

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)			RELATIONSHIP
BILLING ADDRESS			PHONE # ( )

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	BENEFIT CODE
			I.D.#
2) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	BENEFIT CODE
			I.D.#
MEDICARE I.D.#		MEDICAID I.D.#	

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. Alaiti ______ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Alaiti ______, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE * MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT NAME *(please print)* ______ DATE ______

PARENT / GUARDIAN *(please print)* ______ SIGNATURE ______

TO BE COMPLETED BY PATIENT - PLEASE PRINT

HEALTH QUESTIONNAIRE

REASON FOR VISIT

FAMILY HISTORY

FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX

	ALIVE & WELL	DECEASED	CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORIASIS	ECZEMA
FATHER																					
MOTHER																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
MOTHER'S RELATIVES																					
FATHER'S RELATIVES																					

HOSPITAL ADMISSIONS *Indicate the year you were admitted to hospital and the reason. Do not include normal pregnancies.*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS

List all medications that you are now taking. Include over the counter Rx

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

DRUG ALLERGIES

MEDICAL HISTORY *Mark (c) for current problems. Check (✓) box and indicate age when you had any of the following symptoms or diseases.*

☐ HEARING PROBLEMS
☐ GLAUCOMA ☐ CATARACTS
☐ NOSE BLEEDS ☐ SINUS TROUBLE
☐ HOARSENESS ☐ HAY FEVER
☐ ASTHMA ☐ HYPERTENSION
☐ CORONARY HEART DISEASE
☐ HEART MURMUR
☐ PALPITATIONS ☐ IRREG. PULSE
☐ VARICOSE VEINS ☐ PHLEBITIS
☐ DIFFICULTY SWALLOWING ☐ HEARTBURN
☐ PEPTIC ULCER DISEASE ☐ COLITIS
☐ JAUNDICE ☐ HEPATITIS
☐ KIDNEY STONES ☐ PROSTATE PROB.
☐ VENEREAL DISEASE ☐ HERPES

☐ CHLAMYDIA ☐ GONORRHEA
☐ RECENT WEIGHT LOSS
☐ ANEMIA ☐ BRUISE EASILY
☐ CANCER
☐ DIABETES ☐ THYROID DISEASE
☐ SEIZURES ☐ STROKE
☐ MIGRAINE HEADACHES
☐ ARTHRITIS ☐ GOUT
☐ DEPRESSION ☐ MENTAL ILLNESS
☐ TUBERCULOSIS
☐ ALLERGIES (NON DRUG)
ALCOHOL – OZ / WK ______
SMOKING – CIG / DAY ______ #YEARS ______
COFFEE / TEA – CUPS / DAY______

FEMALES
REGULAR MENSTRUAL PERIODS YES ☐ NO
No. OF PREGNANCIES ______
No. OF LIVE BIRTHS ______
No. OF MISCARRIAGES ______
BIRTH CONTROL METHOD ______
B.C. PILL(BRAND)______
MENOPAUSAL SYMPTOMS ☐ YES ☐ NO

SKIN PROBLEMS
☐ ECZEMA ☐ PSORIASIS ☐ RASH
☐ ABNORMAL MOLES ☐ HIVES
☐ FREQUENT SUN EXPOSURES
☐ EXCESSIVE SCARRING
☐ SKIN CANCER
☐ RECENT OR PROGRESSIVE HAIR LOSS