RICHARD E. PECK, MD

PATIENT REGISTRATION

DATE_____ FAMILY/REFERRING DR._____

PATIENT NAME_____ BIRTH DATE____/____/____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

EMAIL_____ DRIVERS LICENSE_____

PATIENT S.S. #_____ PHONE_____ AGE_____

SEX M ☐ F ☐ MARITAL STATUS S ☐ M ☐ W ☐ D ☐ Cell Phone_____

PATIENT EMPLOYER &ADDRESS_____

EMPLOYER PHONE_____

REASON FOR VISIT_____ IS VISIT DUE TO AN INJURY ☐YES ☐NO

REFERRED BY WHOM_____

SPOUSE OR NEAREST RELATIVE_____ PHONE_____

ADDRESS_____ RELATIONSHIP_____

RESPONSIBLE PERSON NAME_____ S.S. #_____

ADDRESS_____

PHONE (H)_____ (W)_____ RELATIONSHIP_____

EMPLOYER & ADDRESS_____

INSURANCE INFORMATION

PRIMARY CARRIER_____ Card Holder Name_____

ADDRESS_____ Card Holder Date of Birth_____

I D #_____ GROUP # _____ PLAN_____

SECONDARY CARRIER_____ Card Holder Name_____

ADDRESS_____ Card Holder Date of Birth_____

I D #_____ GROUP #_____ PLAN_____

I HEREBY AUTHORIZE ESSEX SURGICAL, LLC, AND /OR THE ANESTHESIOLOGIST TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PREVIOUSLY NAMED PARTIES TO BE MADE TO HIM/THEM REGARDLESS OF MY INSURANCE BENEFITS. PHOTOCOPIES OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. OUTSIDE LABORATORY FEES ARE THE PATIENTS RESPONSIBILITY.
WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THIS MAY INCLUDE FAXING INFORMATION FOR HEALTHCARE PURPOSES AND BILLING, AS WELL AS LEAVING MESSAGES FOR APPOINTMENTS AND HEALTH CARE (PRE/POST OPERATIVE CALLS ARE INCLUDED).

NAME_____ DATE_____

PATIENT SIGNATURE/RESPONSIBLE PERSON

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

YOUR NAME_____DATE_____

	YES	NO	EFFECT		YES	NO	EFFECT
PENICILLIN	☐	☐	_____	TAPE	☐	☐	_____
OTHER MEDICATION	☐	☐	_____	HAY FEVER	☐	☐	_____
_____	☐	☐	_____	FOOD	☐	☐	_____
IODINE	☐	☐	_____	SHELL FOOD	☐	☐	_____
CONTACT ALLERGY	☐	☐	_____	LATEX	☐	☐	_____

EXPLAIN ALLERGIC EFFECTS: _____

DATE OF LAST TETANUS SHOT: _____

ILLNESS & MEDICAL PROBLEMS:

YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	BRONCHITIS
☐	☐	HEART ATTACK	☐	☐	EMPHYSEMA
☐	☐	HEART MURMUR	☐	☐	PNEUMONIA
☐	☐	OTHER HEART PROBLEMS	☐	☐	TUBERCULOSIS
☐	☐	DIABETES	☐	☐	ANESTHESIA PROBLEMS
☐	☐	DIZZY SPELLS	☐	☐	STOMACH ULCER
☐	☐	GLAUCOMA	☐	☐	COLITIS
☐	☐	OTHER EYE TROUBLE	☐	☐	DIVERTICULOSIS
☐	☐	EAR TROUBLE	☐	☐	HEPATITIS
☐	☐	SINUS TROUBLE	☐	☐	MONONUCLEOSIS
☐	☐	DEAF OR HEARING IMP.	☐	☐	GALL BLADDER TROUBLE
☐	☐	NOSE BLEEDS	☐	☐	STROKE
☐	☐	NOSE OBSTRUCTION	☐	☐	SLEEP APNEA/DISORDERS
☐	☐	SWELLING IN NECK	☐	☐	CONVULSIONS/SEIZURES
☐	☐	ASTHMA	☐	☐	THYROID PROBLEMS
☐	☐	HEALING PROBLEMS	☐	☐	KIDNEY / BLADDER PROBLEMS
☐	☐	HERNIAS	☐	☐	VARICOSE VEINS
☐	☐	LOW BLOOD PRESSURE	☐	☐	BLEED EASILY
☐	☐	ARTHRITIS	☐	☐	EYE PROBLEMS
☐	☐	BRUISE EASILY	☐	☐	PARALYSIS
☐	☐	BLEEDING DISORDER	☐	☐	LUNG PROBLEMS
☐	☐	ANKLE SWELL			

☐ ☐ MENTAL / NEUROLOGICAL CONDITION:

EXPLAIN: _____

☐ ☐ CANCER:
YEAR / TYPE: _____

☐ ☐ HAVE YOU HAD A MOLE SCREENING?
DATE:_____

☐ ☐ DO YOU HAVE ANY MOLES / BEAUTY MARKS WHICH ARE IREGULAR, MULTI-COLORED, OR HAVE CHANGED?

WOMEN ONLY

☐ ☐ TENDER BREASTS

☐ ☐ FIRBROCYSTIC DISEASE

☐ ☐ MENSTRUAL PROBLEM

☐ ☐ WERE YOUR CHILDREN BREAST FED

☐ ☐ DO YOU PLAN TO HAVE CHILDREN?

☐ ☐ LUMPS OR RECENT SIZE/COLOR CHANGE

PREVIOUS MAMMOGRAM YEAR:_____

LAST MENSTRAL PERIOD: _____

NUMBER OF CHILDREN: _____

HAVE ANY OF THE ABOVE CONDITIONS APPEARED IN YOUR IMMEDIATE FAMILY? IF SO, SPECEFY:

MEDICAL HISTORY

YOUR NAME _____ WEIGHT_____ HEIGHT _____

SURGERY (OPERATIONS):

1. _____
2. _____
3. _____
4. _____

ADMISSIONS TO HOSPITALS:

1. _____
2.
3. _____
4.
5. _____

MEDICATIONS (ANY DRUG OR MEDICATION) YOU TAKE NOW:

1. _____
2. _____
3. _____
4. _____

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:

FAMILY HISTORY OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:
EXPLAIN:

FAMILY HISTORY: ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?
Mother_____ Father _____
_____ _____
Sister _____ Brother _____
_____ _____