Bluebird Dermatology

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Spring, TX 77388
Ph: 409-753-5720
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NEW PATIENT REGISTRATION

Name: _____ Nickname: _____
DOB: ____/____/_____ Gender: M ___ F ___ Other ___ Email address: _____
Home Address: _____ City, State _____ Zip _____
Home phone #: _____ Marital Status: _____

For patients under the age of 18:

School: _____ Current grade: _____ Hobbies/Sports: _____
Mother's Name: _____ Cell:_____
Mother's Occupation: _____ Mother's Email: _____
Father's Name: _____ Cell: _____
Father's Occupation: _____ Father's Email:_____
Siblings (names and ages): _____

Patient lives with: _____
Patient's Occupation (if applicable): _____

How did you hear about us?_____

EMERGENCY CONTACT
Who would you like us to contact in case of an emergency?
Name: _____ Relationship: _____
Primary #: _____ Home ( ) Cell ( ) Work ( )
Secondary _____ Home ( ) Cell ( ) Work ( )

PRIMARY CARE, REFERRAL & OTHER INFO
Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____
Are other family members a patient of Dr. Meena's? _____

PREFERRED PHARMACY INFORMATION
Pharmacy Name: _____ Phone: _____
Pharmacy Address: _____

***If you require refills, please have your pharmacy fax requests to us directly before you call the office. This will help us get refills to you quicker.

Current skin problem (include onset, timing, location, associated symptoms, previous treatments with responses):
_____
_____
Current skin care regimen (soaps, moisturizers, detergents, over-the-counter medications, etc.) if any:
_____
Health conditions: _____
Previous surgeries or hospitalizations: _____
Medications (including vitamins/supplements): _____
Allergies to medications, food, etc.: _____
Weight: _____ Height: _____

Review of Systems	**Yes**	**No**	**Family History**	**Yes**	**No**	**Relationship**
Recent fever			Skin cancer			
Weight loss or gain			Melanoma			
Tiredness			Other cancers (not skin)			
Vision changes			Eczema			
Ear/nose/throat pain			Psoriasis			
Swollen glands			Scarring acne			
Recurrent infection			Other skin problems			
Runny nose/nasal congestion			Asthma			
Cough			Hay fever			
Breathing problems			Thyroid problems			
Heart problems			Autoimmune disorders			
Bleeding problems			Bleeding problems			
Nausea/vomiting/diarrhea			Anesthesia problems			
Muscle aches/weakness			**Social History**	**Yes**	**No**	**Explanation**
Swollen joints/joint pain			Goes to daycare			
Kidney/bladder issues			Vaccines up to date			
Irregular periods			Pets			
Headaches			Alcohol use			
Depression/anxiety			Tobacco use			
Difficulty sleeping			Illicit drug use			
Hair loss			Sexually active			

Person completing form and relationship to patient: _____