ROBIN GAIL OSHMAN, M.D., Ph.D.
101 Long Lots Road
WESTPORT, CT 06880

REGISTRATION SLIP

Please Print

NAME:_____

ADDRESS:_____CITY/STATE_____

CELL PHONE: _____ZIP_____

PHONE: ( )_____SOCIAL SECURITY#_____

EMAIL ADDRESS: _____

BIRTHDATE___/___/____ F___M___ MARRIED___SINGLE___DIV.___WID.____

EMPLOYER:_____WORK PHONE:( )_____
NEXT OF KIN:_____RELATIONSHIP_____PHONE_____

SPOUSE'S NAME:_____EMPLOYER_____PHONE_____

INSURED NAME(if not patient)_____SS#_____
ADDRESS_____CITY_____STATE_____ZIP_____

REFERRED BY:_____

PRIMARY CARE PHYSICIAN:_____

MEDICARE: YES_____NO____ MEDICARE NUMBER_____

PRIMARY INSURANCE:_____

POLICY NUMBER: _____
PATIENT'S RELATIONSHIP TO INSURED: SELF___SPOUSE___CHILD___OTHER____
SECONDARY INSURANCE:_____
POLICY NUMBER:_____GROUP NUMBER:_____
PHARMACY:_____PHONE( )_____

The patient is responsible for fees in this office at the time of service unless prior arrangements have been made.

SIGNED:_____DATE___/___/_____

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:
To help give you the best possible care, please carefully complete
all questions on this form. If unaware of an answer, leave it blank.

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:

1.Duodenal or peptic ulcer…… yes no
2.Other intestinal disease or colitis…….yes no
3.Liver disease or gall bladder disease…….. yes no
4.Lung disease (tuberculosis,pleurisy,other)…….. . yes no
5.Heart disease(rheumatic fever, pacemaker, other)…… yes no
6.High blood pressure…….. yes no
7.Stroke…….. yes no
8.Kidney disease…….. yes no
9.Urinary or bladder disorder or infection…… yes no
10. Venereal disease…….. yes no
11.Blood disorder or lymph gland disorder…….. yes no
12. Eye disease(glaucoma, cataract,cataract surgery,other)…….. yes no
13. Arthritis, joint disorder, or bone disorder…… yes no
14. Thrombophlebitis…….. yes no
15.Cancer…… yes no
16. Frequent infections…… yes no
17. Neurological disorder…….. yes no
18. Emotional or psychiatric disorder…….. yes no
19. Endocrine disease (thyroid, diabetes, other)…… yes no

HAVE YOU OR ANY BLOOD RELATIVE HAD (Specify Who)

1.Asthma…… yes no
2.Hay fever…….. yes no
3.Eczema…….. yes no
4.Hives…….. yes no
5.Diabetes…….. yes no
6.Psoriasis…….. yes no
7.Skin cancer…….. yes no
8.Glaucoma…….. yes no
9.Other skin conditions…….. yes no

HAVE YOU EVER HAD

1.Excessive bleeding when cut…….. yes no
2. Difficulty healing wounds…… yes no
3. Overgrown scars or keloids…… yes no
4. Allergy to local anesthetics…….. yes no

HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST?
Please Describe:_____
_____

HAVE YOU EVER RECEIVED X-RAY, GRENZ RAY OR ULTRA-VIOLET LIGHT (UVB,UVA) TREATMENTS TO YOUR SKIN?..... ……YES____NO_____.
_____

DO YOU TAKE ANY MEDICINES, DRUGS OR OVER-THE-COUNTER REMEDIES?
(e.g. medicines for sleep, constipation, headaches, "nerves", birth control or vitamins)……..YES NO
If yes, please list_____
_____

ARE YOU ALLERGIC TO ANY MEDICINES, DRUGS OR OVER-THE COUNTER PREPARATIONS……YES NO
If yes please list_____
_____
_____

LIST ANY PRIOR HOSPITALIZATIONS AND/OR SURGERY
(Please give approximate dates)
_____
_____
_____

FOR WOMEN ONLY

1. Have you had vaginal yeast infections?..... yes no
2. Are you pregnant?.....yes no
3. Are you currently planning a pregnancy?.....yes no

Please inform the doctor if you do plan to or become pregnant at any time during your treatment period.

NOTE: The dermatological examination which you are about to receive is not a complete physical examination. It is suggested that you have a complete physical examination periodically by your family physician or internist.

SIGNATURE_____DATE_____