Samson Aesthetics, LLC
Michel C. Samson, MD

REGISTRATION FORM (Please Print)

Today's Date / /

PATIENT INFORMATION

Patient's Last Name	First	Middle		Marital Status (Circle One)	
			◦ Mr. ◦ Miss ◦ Mrs. ◦ Ms.	◦ Single ◦ Partnered ◦ Married	◦ Separated ◦ Divorced ◦ Widowed

Home Phone #	Cell Phone #	Birth Date / /	Age	Sex ◦ M ◦ F

Street Address / P.O. Box	Social Security	Email Address:
City / State / Zip Code		Consent for Email Communications ❑ Yes ❑ No

Occupation	Employer	Employer Phone No. ( )

Referred to by (Please check one box) ◦ Dr. _____ ◦ Insurance Plan ◦ Hospital

◦ Family ◦ Friend ◦ Close to Home/Work ◦ Website ◦ Yellow Pages ◦ NewsPaper ◦ Radio

◦ Other

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone #
Is this person a patient here? ◦ Yes ◦ No			

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by Insurance? ◦ Yes ◦ No

Please indicate Primary Insurance:

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ◦ Self ◦ Spouse ◦ Child ◦ Other

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ◦ Self ◦ Spouse ◦ Child ◦ Other

EMERGENCY CONTACT (OTHER THAN YOUR OWN)

Name :	Relationship to Patient	Home Phone #	Cell Phone #

Primary Care Dr:

The above information is true to the best of my knowledge. I authorize the physicians of **Samson Aesthetics, LLC** to provide myself or my child/ward with reasonable and proper medical care according to today's standards. I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I also authorize **Samson Aesthetics, LLC** or the insurance company to release any information required to process my claims. I understand that **Samson Aesthetics, LLC** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Samson Aesthetics, LLC,** I agree to forward to **Samson Aesthetics, LLC** all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. ***I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.***

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE

PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICE IS POSTED IN THE OFFICE RECEPTION AREA. IF YOU WOULD LIKE A COPY OF THIS NOTICE PLEASE ADVISE THE RECEPTIONIST.

NAME _____ DATE _____

MEDICAL HISTORY SHEET

HEIGHT _____ WEIGHT _____

PLEASE LIST PREVIOUS OPERATIONS:

Operation	When	Where	Surgeon

PLEASE LIST PREVIOUS SERIOUS ILLNESSES AS A CHILD OR AN ADULT:

_____

_____

_____

PLEASE CIRCLE YES OR NO

Yes No Do You Smoke? How Much _____ (packs a day)
Yes No Do You Drink Alcohol? How Much _____
Yes No Do You Take Aspirin Regularly?
Yes No Do You Take Any Blood Thinners? (If Yes List Below)

_____

Yes No Do You Take Cortisone or Other Steroids (If Yes List Below)

_____

List Any Medicines You Take Regularly and Please Include Dosage:

_____

_____

_____

_____

_____

Yes No ARE YOU ALLERGIC TO ANY MEDICINES? IF SO, LIST BELOW:

_____

_____

_____

HAS ANY FAMILY MEMBER HAD BLEEDING PROBLEMS?

Yes No

HAS ANY FAMILY MEMBER HAD SICKLE CELL DISEASE?

Yes No

HAS ANY FAMILY MEMBER HAD PROBLEMS WITH GENERAL ANESTHESIA?

Yes No

DO YOU HAVE:

Yes No	BLEEDING PROBLEMS	Yes	No	BLOODY STOOLS
Yes No	DIABETES	Yes	No	BLACK, TARRY STOOLS
Yes No	HIGH BLOOD PRESSURE	Yes	No	DIFFICULTY WITH URINATION
Yes No	FREQUENT HEADACHES	Yes	No	BLOOD IN URINE
Yes No	PROBLEMS WITH EYESIGHT	Yes	No	PAIN IN JOINTS OR BONE
Yes No	RINGING IN EARS	Yes	No	PARALYSIS OF ANY MUSCLES
Yes No	HAY FEVER	Yes	No	SEIZURES
Yes No	CHRONIC NASAL CONGESTION	Yes	No	FAINTING SPELLS
Yes No	SORES IN MOUTH OR THROAT	Yes	No	EMOTIONAL PROBLEMS
Yes No	SHORTNESS OF BREATH			FOR WOMEN ONLY:
Yes No	CHRONIC COUGH			Last Menstrual Period _____
Yes No	COUGH WITH BLOODY SPUTUM			Number of Pregnancies _____
Yes No	CHEST PAIN			Type of Deliveries _____
Yes No	HEART DISEASE			Miscarraiges
Yes No	RAPID HEART RATE	Yes	No	Menstrual Irregularity
Yes No	IRREGULAR HEART BEATS	Yes	No	Breast Lumps
Yes No	STOMACH PAINS	Yes	No	Nipple Discharge
Yes No	FREQUENT DIARRHEA	Yes	No	Mother or Sister With
Yes No	CHRONIC CONSTIPATION			Breast Cancer