Patient Registration Form

Please complete this form on the computer and e-mail it to us at office@dexteritysurgical.com. You may also print it out and bring it to your first visit. If you do not already have an appointment, we will call you within 24 hours of the next business day to schedule your visit.

General Information

Last Name: ______________________ First Name: ______________________ MI: ___

Preferred Name: ________________________________ Date of Birth: ____________

Address: ____

City: ________________________________ State: ___ Zip Code: _______________

Home Phone: _____________ Cell Phone: _____________ Work Phone: _____________

E-mail Address: ________________________________ Contact Preference: _________

Emergency Contact Name: _________________________ Relationship: ____________

Contact Home Phone: ___________________ Contact Cell Phone: __________________

Preferred Pharmacy: ___________________ Address: __________________________

Insurance Information

Policy Holder Name: _________________________ Relationship to Policy Holder: _______

Primary Insurance: ________________________________ Member ID: _____________

Group/Policy Number: _____________ Primary Care Physician: ______________________

Secondary Insurance: ______________________________ Member ID: _____________

Is this a Worker's Compensation Claim? ☐ Yes ☐ No If Yes, please complete the following:

Worker's Compensation Carrier: ___________________ Claim Number: ______________

Adjuster Name: ________________________________ Phone: __________________

Employer: ________________________________ Date of Injury: ________________

Reason for Visit

Reason for Visit: ____

____

Is this for an Automotive Accident? ☐ Yes ☐ No

Dexterity Surgical, LLC | Virginia Hung, MD
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Past Medical History

Please check off any medical conditions you have or have had problems with in the past.

General Health
- Obesity ☐

Eyes
- Cataract ☐
- Diabetic Retinopathy ☐
- Glaucoma ☐
- Visual Disturbance ☐

Ear, Nose and Throat
- Hearing Loss ☐
- Sinusitis/Sinus Drainage ☐

Respiratory
- Asthma ☐
- COPD ☐
- Problems with Intubation ☐
- Recurrent Pneumonia ☐
- Sleep Apnea with CPAP ☐

Cardiac
- Angina ☐
- Cardiac Bypass ☐
- Cardiac Catheterization ☐
- Congestive Heart Failure ☐
- High Blood Pressure ☐
- Irregular Heart Rhythm ☐
- Pacemaker ☐

Vascular
- Atherosclerosis ☐
- Other Arterial Disease ☐
- Venous Insufficiency ☐
- Other Venous Disease ☐

Gastrointestinal
- Crohn's Disease ☐
- Dysphagia ☐
- Gall Stones ☐
- Gastric Ulcers ☐
- Gastroesophageal Reflux ☐
- Hepatitis ☐

Genitourinary
- Diabetic Nephropathy ☐
- Enlarged Prostate ☐
- Erectile Dysfunction ☐
- Hysterectomy ☐
- Kidney/Bladder Infection ☐
- Kidney Stones ☐

Musculoskeletal
- Back Pain ☐
- Back Injury ☐
- Fibromyalgia/Myositis ☐
- Gout ☐
- Osteoarthritis ☐
- Osteoporosis ☐
- Previous Fracture(s) ☐

Heme/Lymph
- Anemia ☐
- Bleeding/Bruising disorder ☐
- High Cholesterol ☐
- Lymphedema ☐

Endocrine
- Diabetes:
  - *Insulin Dependent* ☐
  - *Medication Controlled* ☐
  - *Diet Controlled* ☐
- Hyperthyroidism ☐
- Hypothyroidism ☐

Neurologic
- Anxiety ☐
- Dementia ☐
- Depression ☐
- History of Stroke ☐
- History of Seizures ☐
- Other Mental Illness ☐

Autoimmune/Allergy
- CREST Syndrome ☐
- Environmental Allergies ☐
- HIV/AIDS ☐
- Lupus ☐
- Psoriasis ☐
- Psoriatic Arthritis ☐
- Rheumatoid Arthritis ☐
- Scleroderma ☐

Cancer
- Breast ☐
- Lung ☐
- Prostate ☐
- Colon ☐
- Skin ☐
- Leukemia/Lymphoma ☐
- Other (List Below) ☐

If yes to any of the above, please describe the condition or list any other conditions you may have:

____

____

____

Past Surgical History

Please list any previous surgery with the approximate dates:

Procedure	Date	Procedure	Date

Medications

Please attach or list any prescription, non-prescription, and herbal medications you are taking:

Do you have any medication allergies? ☐ Yes ☐ No

If yes, please list the medication and reaction here: ____

____

____

Social History

Do you smoke? ☐ Yes ☐ No If no, did you ever smoke? ☐ Yes ☐ No

If yes to either, for how many years? _________ How many packs per day? _________

Marital Status: ☐ Married ☐ Single ☐ Divorced Name of significant other: _________________

On average, how many alcoholic drinks do you have per week? _________

Have you had problems with substance abuse? ☐ Yes ☐ No

If yes, please describe: ____

Vital Signs

We will collect your vitals at your visit, please enter your height: _________ and weight: _________

Review of Systems

Please review the following list and place a check mark next to any problems you are currently having. This will assist Dr. Hung in addressing your concerns and make your time together more productive.

General:	☐ Fever ☐ Night Sweats ☐ Weight Gain (____lbs) ☐ Weight Loss (____lbs)
	☐ Exercise Intolerance
Skin:	☐ Mole ☐ Jaundice ☐ Rash ☐ Itching ☐ Dry Skin ☐ Growths/Lesions
Psychiatric:	☐ Depression ☐ Sleep Disturbance ☐ Feeling Unsafe in Relationship ☐ Alcohol Abuse
Eyes:	☐ Dry Eyes ☐ Irritation ☐ Vision Changes
Ears:	☐ Difficulty Hearing ☐ Ear Pain
Nose:	☐ Frequent Nosebleeds ☐ Nose/Sinus Problems
Mouth/Throat:	☐ Sore Throat ☐ Bleeding Gums ☐ Snoring ☐ Dry Mouth ☐ Mouth Ulcers
	☐ Oral Abnormalities ☐ Teeth Problems ☐ Mouth Breathing
Respiratory:	☐ Cough ☐ Wheezing ☐ Shortness of Breath ☐ Coughing up Blood ☐ Sleep Apnea
Cardiovascular:	☐ Chest Pain ☐ Arm Pain on Exertion ☐ Shortness of Breath When Walking
	☐ Shortness of Breath When Lying Down ☐ Palpitations ☐ Known Heart Murmur
	☐ Light-Headed on Standing
Gastrointestinal:	☐ Abdominal Pain ☐ Vomiting ☐ Change in Appetite ☐ Black or Tarry Stools ☐ Diarrhea
	☐ Vomiting Blood
Genitourinary:	☐ Incontinence ☐ Difficulty Urinating ☐ Increased Urinary Frequency ☐ Blood in Urine
	☐ Incomplete Emptying
Musculoskeletal:	☐ Muscle Aches ☐ Muscle Weakness ☐ Joint Pain ☐ Back Pain ☐ Swelling in Extremities
Neurologic:	☐ Loss of Consciousness ☐ Weakness ☐ Numbness ☐ Seizures ☐ Dizziness
	☐ Headaches ☐ Restless Legs
Endocrine:	☐ Fatigue ☐ Increased Thirst ☐ Hair Loss ☐ Increased Hair Growth ☐ Cold Intolerance
Hematologic:	☐ Swollen Glands ☐ Easy Bruising ☐ Excessive Bleeding
Allergic:	☐ Runny Nose ☐ Sinus Pressure ☐ Itching ☐ Hives ☐ Frequent Sneezing

Please mention any other symptoms or concerns to the medical assistant or Dr. Hung.