

Richard L. Kofkoff, M.D., F.A.C.S.

**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION:**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle init.: \_\_\_\_\_ Sex: M F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Marital status: M S D W SEP SSN: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Spouse's name: \_\_\_\_\_ Employer: \_\_\_\_\_  
E-mail address: \_\_\_\_\_

**EMERGENCY CONTACT:** Nearest relative/friend we may contact if needed.

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**REFERRAL SOURCE:** Whom may we thank for referring you to our practice?

Doctor: \_\_\_\_\_ Friend/Patient: \_\_\_\_\_ Hospital: \_\_\_\_\_  
(name) (circle one) (name) (name)  
Yellow Pages: \_\_\_\_\_ Radio/TV: \_\_\_\_\_ Other: \_\_\_\_\_  
(station) (describe)

**CONSENTS**

**CONSENT TO TREATMENT:**

I hereby consent to medical treatment rendered by Richard L. Kofkoff, M.D.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

(If patient is a minor, parent or legal guardian must sign)

**CONSENT FOR PHOTOGRAPHY:**

Pre-treatment and post-treatment photographs are recommended to follow your medical care. Pre-treatment and post-treatment photos may be viewed for educational purposes by our patients or prospective patients.

I (print name), \_\_\_\_\_, release my pre/post-treatment photographs for use by Richard L. Kofkoff, M.D.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

(If patient is a minor, parent or legal guardian must sign)

**PLEASE COMPLETE THE BACK OF THIS FORM**

# MEDICAL HISTORY

**CONFIDENTIAL RECORD:** Information contained below will not be released unless you have authorized us to do so. This information is important as it will be used by our practice in making decisions regarding your care.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

The reason for your consultation today: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_ Doctor: \_\_\_\_\_

PLEASE CIRCLE YES OR NO IF YOU HAVE (OR HAVE HAD) A PERSONAL HISTORY OF ANY OF THE BELOW:

If yes, please list date of onset.

|                                     |     |    |             |
|-------------------------------------|-----|----|-------------|
| Cancer                              | Yes | No | Date: _____ |
| High Blood Pressure                 | Yes | No | Date: _____ |
| Stroke                              | Yes | No | Date: _____ |
| Heart Attack                        | Yes | No | Date: _____ |
| Chest Pain                          | Yes | No | Date: _____ |
| Mitral Valve Prolapse               | Yes | No | Date: _____ |
| Breathing Difficulties              | Yes | No | Date: _____ |
| Diabetes                            | Yes | No | Date: _____ |
| Hepatitis                           | Yes | No | Date: _____ |
| AIDS                                | Yes | No | Date: _____ |
| Excessive Bleeding                  | Yes | No | Date: _____ |
| Psychological History               | Yes | No | Date: _____ |
| Arthritis                           | Yes | No | Date: _____ |
| Artificial Joints, Implants, Valves | Yes | No | Date: _____ |
| Smoking                             | Yes | No | Date: _____ |

PLEASE CIRCLE YES OR NO IF YOU ARE CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS.

If yes, please list medication.

MEDICATION NAME & DOSAGE:

|                           |     |    |       |
|---------------------------|-----|----|-------|
| Antibiotics               | Yes | No | _____ |
| Aspirin, Ibuprofen, etc.  | Yes | No | _____ |
| Blood Pressure Medication | Yes | No | _____ |
| Blood Thinning Medication | Yes | No | _____ |
| Birth Control Medication  | Yes | No | _____ |
| Diabetic Medication       | Yes | No | _____ |
| Heart Medication          | Yes | No | _____ |
| Water Pills               | Yes | No | _____ |
| Pain Medication           | Yes | No | _____ |
| Herbal Products           | Yes | No | _____ |
| Psychological Medication  | Yes | No | _____ |
| Other Drugs Not Listed    | Yes | No | _____ |

PREVIOUS SURGERY: Please list type and date. \_\_\_\_\_

ALLERGIES: Please list any known medicine or anesthesia allergies/reactions you have encountered:

IF NO KNOWN ALLERGIES, CHECK HERE  \_\_\_\_\_