Circle **any of the following medical conditions that you currently have:**

Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

PLEASE LIST ALL OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

_____

Past Surgeries- Have you had any surgeries on the following organs?

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast : Breast Biopsy
Breast : Lumpectomy (Both Breasts)
Breast : Lumpectomy (Left Breast)
Breast : Lumpectomy (Right Breast)
Breast : Mastectomy (Both Breasts)
Breast : Mastectomy (Left Breast)
Breast : Mastectomy (Right Breast)
Colon (Colectomy) : Colon Cancer Resection
Colon (Colectomy) : Diverticulitis
Colon (Colectomy) : Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart : Biological Valve Replacement
Heart : Coronary Artery Bypass Surgery
Heart : Heart Transplant
Heart : Mechanical Valve Replacement
Heart : PTCA
Joint Replacement : Hip (Both)
Joint Replacement : Hip (Left)
Skin : Melanoma, Basal, Squamous
Testicles (Orchiectomy)
Spleen (Splenectomy)Fibroids
Uterus (Hysterectomy) : Uterine Cancer
Uterus (Hysterectomy):Cervical Cancer
Uterus (Hysterectomy):
Joint Replacement : Hip (Right)
Joint Replacement : Knee (Both)
Joint Replacement : Knee (Left)
Joint Replacement : Knee (Right)
Kidney : Kidney Biopsy
Kidney : Kidney Stone Removal
Kidney : Kidney Transplant
Kidney : Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy) : Endometriosis
Ovaries (Oophorectomy) : Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy

Past Surgeries Continued:

Prostate (Prostatectomy) : Prostate Biopsy
Prostate (Prostatectomy) : Prostate Cancer
Prostate (Prostatectomy) : TURP
Rectum: APR
Rectum: Low Anterior Resection

Other: _____
_____
_____

Do you have any Family History of any medical Conditions?

1.	3.	5.
2.	4.	6.

Have you had any of the following skin conditions

Acne	Flaking or Itchy Scalp
Actinic Keratoses	Hay Fever/Allergies
Asthma	Melanoma
Basal Cell Skin Cancer	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Eczema
Psoriasis	Squamous cell skin cancer

Any Other skin conditions:_____

_____

Do you wear Sunscreen? **YES/NO** Do you tan in a tanning salon? **YES/NO**

Do you have a family history of Melanoma? **YES/NO** If yes, which relative? _____

PLEASE LIST ALL CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS

1.	3.	5.
2.	4.	6.

PLEASE LIST ANY ALLERGIES TO MEDICATION

1.	3.	5.
2.	4.	6.

What pharmacy would you like us to send your medications to?
Name:_____
City:_____
Cross Streets:_____

DO YOU SMOKE CIGARETTES**? YES/NO**
DO YOU DRINK ALCOHOL**? YES/NO**
DO YOU RECEIVE FLU SHOTS**? YES/NO**
IF **18** OR YOUNGER, ARE YOU UP TO DATE ON ALL IMMUNIZATIONS? **YES/NO**

NOTIFICATIONS FROM OUR OFFICE
Is it ok to send Text message/Email reminders for appointments? **YES/NO**
Is it ok to leave detailed voicemails regarding pathology results? **YES/NO**

Only fill out next section if 65 years of age or older

1.Have you received a pneumonia vaccination**? YES/NO**
2. Have you Received the shingles vaccine? **YES/NO**

2.Do you have a family member or friend who can, in the event you are unable to make your own medical decisions, make medical decisions for you. If yes please list their name and number.

Name:_____ **Number**:_____

3.Do you have a living will or trust? **YES/NO**

4.Which statement best reflects your wishes? **(PLEASE CIRCLE ONE BELOW)**
***Do Not Intubate:** I do not wish to have a breathing tube, even if it is necessary to save my life.
***Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it Is necessary to save my life.
***Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation efforts to be made.

REVIEW OF SYSTEMS

Are you currently experiencing any of the symptoms listed below? Please circle,

itching
Rash
changing mole
non-healing skin
problems with scarring
Recent sun exposure
Increased stress level
problems with bleeding
asthma
muscle weakness
hay fever
unintentional weight loss
fatigue
fever or chills
joint aches
blurry vision Eyes
anxiety
depression
thyroid problems

What pharmacy would you like us to send your medications to?

Name:_____
City:_____
Cross Streets:_____

James T. Wang, M.D. Inc Patient Registration

Name:_____

Last First M.I.

Birthdate:___/___/_____ SS#_____-_____-_____ Gender:_____

Marital Status:_____

Home Address:_____

City_____St_____Zip Code_____

Email:_____ **Cell #**_____

Home phone #_____ Work#_____

Emergency contact Name:_____ Number_____

Responsible party if patient is a Minor:_____

Responsible party's address:_____

Responsible party's Phone #:_____

**I hereby assign all medical and surgical insurance benefits to James. T. Wang, M.D. A copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all services whether or not covered or paid by insurance (e.g. deductible, Co-Pay, Co-insurance). It is my responsibility to know the details of my own plan. I hereby authorize said assignment to release all necessary information to my insurance company to secure payment.*

Signed(Patient or Guardian):_____ Date:___/___/____

Please print name:_____

Late Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide a 24 hours notice. This will enable us to schedule another patient in that appointment slot. ***PLEASE BE ADVISED*** That there will be a **$25 fee** to those who either do not show up for their appointment or do not cancel within 24 hours.

Signed(Patient or Guardian):_____ Date:___/___/____

Please print name:_____

How did you hear about our office? (please circle)

Zocdoc	Google	Insurance Directory
Dr. Referral	Friend/Patient Referral	HMO Referral
Yellow Pages	Yelp	