Please complete this form before your scheduled appointment and send to info@drberger.com

DR. BERGER - REGISTRATION FORM

Date _____

First Name _____ Last Name _____ Nickname _____
Home Phone _____ Cell Phone _____ Work Phone _____
Home Street Address _____
City _____ State _____ Zip _____
Occupation / Employer _____
Work Street Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Driver's Lic. No. _____ Soc. Sec. No. _____
Marital Status : ☐single ☐married ☐widowed ☐divorced ☐separated
Emergency Contact(s) _____

Medical Information

Please list all prescription or over-the-counter medications you are currently taking, or have taken in the last 2 months (including the dose):

_____
_____
_____

Do you have any allergies? ☐NO ☐YES - If yes, please list: _____
_____

Have you taken any steroids (ex. prednisone) or any hormones (ex. birth control pills, estrogen/progesterone/testosterone) in the past year? ☐NO ☐YES

Are you taking diet pills, vitamins, herbal products, homeopathics or supplements? ☐NO ☐YES

Have you ever been diagnosed with any type of cancer or treated with chemotherapy? ☐NO ☐YES

Have you, or any family members, had any adverse reactions to anesthesia or surgery? ☐NO ☐YES

Have you or any family members experienced any bleeding or clotting problems? ☐NO ☐YES

Please list all surgeries both cosmetic and non-cosmetic:

_____
_____
_____

Have you been hospitalized for any reason other than surgery? ☐NO ☐YES - If yes, please describe:
_____
_____

Have you ever smoked? ☐NO ☐YES – If yes, do you currently smoke? ☐NO ☐YES

Do you consume alcohol? ☐NO ☐YES

Do you use “recreational” drugs or marijuana (*this information is confidential*)? ☐NO ☐YES

When was your last medical exam? _____ Who is your primary doctor? _____
Primary doctor's telephone:_____

Do any illnesses or conditions run in the family? ☐NO ☐YES - If yes, please list: _____
_____

Please check any conditions that you have had:

☐High Blood Pressure	☐Heart or Valve Conditions	☐Bleeding / Bruising Tendency
☐Anemia	☐Eye Disease or Dry Eye	☐Asthma
☐Blood Transfusions	☐Irregular / Rapid Heart Rate	☐Diabetes
☐Stomach Ulcer	☐HIV+ / AIDS	☐Kidney Disease
☐Autoimmune Condition	☐Hepatitis	☐Thyroid Condition
☐Depression	☐Weight Loss	☐Tuberculosis
☐Radiation Treatment	☐Blood Clots in your Legs	☐Scar Problems

*** For Women Only ***

Total Pregnancies: _____ Live Births _____ Last Mammogram _____ Last menstrual period _____

I verify that the information in this form is accurate and complete to the best of my knowledge.

_____ Date: _____
Patient Name (or parent, if minor) - sign in office

_____
Relationship, if signing for a minor