

# THE LA JOLLA INSTITUTE OF PLASTIC SURGERY

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## PATIENT REGISTRATION FORM

**PLEASE PRINT**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED ( ) SEPARATED ( )

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: HOME: ( ) \_\_\_\_\_ CEL: ( ) \_\_\_\_\_ PAGER: ( ) \_\_\_\_\_

WHICH PHONE NUMBER MAY WE LEAVE A MESSAGE: HOME ( ) CELL ( ) OTHER: ( ) \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ CA DRIVERS LICENSE # \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

\_\_\_\_\_  
Family Doctor Phone

\_\_\_\_\_  
Internist Phone

\_\_\_\_\_  
Gynecologist Phone

\_\_\_\_\_  
Specialist Phone

REFERRAL SOURCE: \_\_\_\_\_

NAME OF SPOUSE, PARENT OR RESPONSIBLE PARTY: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

**PLEASE DESCRIBE THE REASON(S) FOR THIS INITIAL CONSULTATION:**

\_\_\_\_\_  
\_\_\_\_\_

**ARE YOU INTERESTED IN DISCUSSING SKIN CARE WITH DR. PIETRASZEK?**  YES  NO

**IF 'YES', WHAT ARE YOUR SPECIFIC CONCERNS:** \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date