**MARK VINCENT SOFONIO, M.D., F.A.C.S.**

BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGEON

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# PATIENT REGISTRATION

 Date: \_\_\_/\_\_\_/\_\_\_\_ May we contact you to confirm appointments, etc.? ⁯ Yes ⁯ No

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH**: \_\_\_/\_\_\_\_/\_\_\_\_\_

 LAST FIRST

**YOUR AGE**: \_\_\_\_\_\_ **FEMALE: ⁯ MALE: ⁯** **OTHER ⁯** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: ⁯ Single ⁯ Married ⁯ Widowed ⁯ Divorced SPOUSE OR SIGNIFICANT OTHER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE:\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_

SECONDARY ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_

**HOME PHONE :(\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ CELL PHONE :(\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ WORK PHONE :(\_\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_**

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRIVERS LICENSE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_

**EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_ May we send you information regarding specials, etc. ⁯ Yes ⁯ No**

**How did you hear about us**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had a cosmetic procedure before? ⁯ Yes ⁯ No

**Please describe The Reason For Today’s Consultation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Allergies** (check all that apply): ⁯Latex ⁯ Aspirin ⁯ Ibuprofen ⁯ Animals ⁯ Pollen/Hay Fever ⁯ Fragrance/Perfume

⁯ “cillin” Medications ⁯ “caine” Medications (example: lidocaine, benzocaine) ⁯ Metals Foods (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cosmetic Ingredient Sensitivity or Allergies** (check all that apply): ⁯ Aloe Vera ⁯ Sulphur ⁯ Benzoyl Peroxide ⁯ Hydroquinone

⁯ Progesterone

⁯ Glycolic ⁯ Cortisone ⁯ Vitamin C Topical ⁯ Vitamin E Topical ⁯ Sunscreen ⁯ Retin A/Retino

Do You Have Any Metal Implants? ⁯ No ⁯ Yes: (Location?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Have an Implanted Cardioverter/Defibrillator, Pacemaker or Heart Valve? ⁯ No ⁯ Yes

Have You ever Had Bad Experience in the Dental Office? ⁯ No ⁯ Yes (Why?):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Currently Seeing a Dermatologist? ⁯ No ⁯ Yes (Why?):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Major Illness, Surgeries, or Chronic Problems (Past 5 Years):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Ever Had a Cosmetic Surgery? (Type & When?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check All Fillers Used: ⁯ Silicone ⁯ Artefil ⁯ Sculptra ⁯ Radiesse ⁯ Juvederm/Restylane ⁯ Collagen ⁯ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check Any of the Following Medical Conditions That Apply:**

Thyroid Condition ⁯ Hormone Imbalance ⁯ Asthma ⁯ Lupus ⁯ Rosacea ⁯ Immune Disorder

⁯ High Blood Pressure ⁯ Epilepsy/Seizures ⁯ HIV ⁯ Hepatitis A⁯ Hepatitis B ⁯ Hepatitis C

 Systemic Disease ⁯ Migraine Headaches ⁯ Diabetes ⁯ Liver Disease Heart Disease ⁯ Genital Herpes

Cancer⁯ Multiple Sclerosis ⁯ Bruise Easily ⁯ History of Stroke ⁯ Kidney Trouble Cold Sores (Frequency/year:\_\_\_\_\_\_)⁯ Myasthenia Gravis ⁯ Parkinson’s Disease Lambert-Eaton ⁯ Lou Gherig’s Disease

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List ALL Prescriptions & Over the Counter Medications You Are Currently Taking**

(Including Aspirin, Ibuprofen, Herbs & Vitamins)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List ALL SURGICAL PROCEDURES THAT WERE NON-COSMETIC:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-DATE\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-DATE\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-DATE\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-DATE\_\_\_\_\_\_\_\_\_\_\_

**Indicate the type(s) of ANESTHESIA received in the past, list any complications/reactions you experienced:**

 Local anesthesia -complications/reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 General anesthesia- complications/reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Spinal/Epidural - complications/reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received a transfusion? ⁯ No ⁯ Yes If yes, what year? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been tested for HIV? ⁯ No ⁯ Yes If yes, what year? \_\_\_\_\_\_\_\_\_\_\_\_\_ Test Results? ⁯ Positive ⁯ Negative**

Primary Care Physician (Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Last Seen By Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Medical Insurance: Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health Questions:**

Tobacco Use: ⁯ Yes ⁯ No Pain Threshold: ⁯ Low ⁯ Medium ⁯ High Regular Sleep Patterns: : ⁯ No ⁯ Yes Alcohol: ⁯ Yes ⁯ No Amount in a week?\_\_\_\_\_drinks Plain Water: (# of 8oz. glasses per day) ⁯ 1-2 ⁯ 3-4 ⁯ 6-8+ Exercise (days per week): ⁯ None ⁯ 1-2 ⁯ 3-4 ⁯ 5 + Claustrophobia: ⁯ Yes ⁯ No Contact Lense: ⁯ Yes ⁯ No Caffeine (soda, coffee, tea per day): ⁯ None ⁯ 1-2 ⁯ 3+ Restricted Diet: ⁯ Yes ⁯ No

**For Women Only – Check Any That Currently Apply:**

Are You Pregnant? ⁯ No ⁯ Yes Do you anticipate becoming pregnant? ⁯ Yes ⁯ No ⁯ Menopausal ⁯ Using Hormone Replacement Therapy ⁯ acne flare-ups that seem related to menstrual cycle ⁯ Nursing until: \_\_/\_\_/\_\_ ⁯ Birth Control (which method?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This practice is governed by the California Medical Board. Be advised that Dr. Mark Sofonio is the sole owner/individual with a financial interest in this practice.

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Patient Signature Date