DERMATOLOGY, LTD.
PATIENT INFORMATION
PLEASE COMPLETE BOTH SIDES

HEALTH HISTORY:

Today's Date ____________
Updated on ____________

Name: ______________________________________ Age: ______
Last First M.I.

Are you allergic to any medications? Yes ___ No ___ If Yes, please list: ____________

Primary Doctor: (Name & Address) ____________

Referred by: Doctor____ Friend____ Relative____ Other____
Are you taking birth control pills? Yes____ No____ Type____________
Have you ever had a severe sunburn? Yes____ No ____
Do you have a pacemaker? Yes____ No ____
Do you have a prescription reimbursement plan? Yes____ No____
Do you take antibiotics before a dental procedure? Yes ____ No ____

Medical Problems, please list:
1 ____________
2 ____________
3 ____________
4 ____________
5 ____________

Prescription Medications, please list
1 ____________
2 ____________
3 ____________
4 ____________
5 ____________

Over the Counter Medications, please list:
(Pain Relief, Laxatives, Vitamins, Herbs)
1 ____________
2 ____________
3 ____________
4 ____________

REVIEW OF SYSTEMS

(Constitutional)
___weight loss ___night sweats
___fevers ___fatigue

(Eyes)
___cataracts ___glaucoma
___blurry vision

(Ears)
___ringing in ears ___hearing loss

(Cardiovascular)
___heart disease ___chest pain
___heart murmur
___high blood pressure

(Respiratory)
___shortness of breath ___sinusitis
___tuberculosis ___cough
___hay fever ___asthma

(Gastrointestinal)
___abdominal pain ___bloody stool
___jaundice ___hepatitis ___ulcer

(Genitourinary)
___frequent urination
___sexually transmitted disease

(Musculoskeletal)
___joint pain ___lupus
___muscle weakness

(Skin)
___eczema ___abnormal mole
___psoriasis ___difficulty healing
___itching ___hives
___bruise easily ___hair loss
___keloids ___lupus
___frequent sun exposure
___skin cancer; type____________

(Neurologic)
___seizures ___headaches
___dizziness

(Endocrine)
___diabetes ___thyroid disease

(Heme)
___anemia ___excessive bleeding

(Cancer)
type____________

SOCIAL HISTORY
Do you smoke? Yes_____ No_____
If yes, how many packs per week _____
Do you drink alcohol? Yes_____ No_____
If yes, how many drinks per day______,
per week ______ .
Occupation____________

List Other (Please explain):____________

List Past Surgeries: ____________

FAMILY HISTORY - PLEASE EXPLAIN IF ANYONE IN YOUR FAMILY HAS HAD ANY OF THE FOLLOWING:

Description/Relation (Mother, Father, etc.)

Skin Cancer, type: (basal cell, squamous cell, melanoma, don't know) ____________

Other Skin Disorders (Psoriasis, Eczema, etc.) ____________

Reviewed by :

John J. Laskas, Jr., M.D. ____________ Christine L. Egan, M.D. ____________

Edward F. Chan, M.D. ____________ Joseph M. Kist, M.D. ____________

In the event of an emergency please notify: Name ____________ Phone # (___) ____________

Relationship ____________ Date ____________

OVER

DERMATOLOGY, LTD.
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Today's Date ____________________
Updated on ____________________

Name: ____
Last **First** **M.I.**

PLEASE CIRCLE :
MR. /MRS./MS./OTHER

PLEASE CIRCLE:
SINGLE /MARRIED/OTHER

PLEASE CIRCLE:
EMPLOYED /FULL-TIME STUDENT /PART-TIME STUDENT

DATE OF BIRTH: __________ **AGE:** __________ **SEX:** __________ **SS #:** __________
Home Phone # ( )__________ Work Phone # ( )__________
Street Address:__________
City: __________ State: __________ Zip Code:__________
Employer's/School's Name: __________
Employer's/School's Address:__________

RESPONSIBLE PARTY INFORMATION - CIRCLE: PARENT SPOUSE GUARDIAN

Name:__________ SS # : __________
Street Address: __________
Mailing Address:__________
Home Phone # ( )__________ Work Phone # ( )__________
Employer:__________ Occupation: __________
Employer's Address: __________

PRIMARY INSURANCE TO FILE

Insurance Company's Name:__________
Insurance Company's Address:__________
Subscriber's Name: __________ Birthdate:__________
Relationship to Patient: Self:__________ Spouse__________ Parent or Guardian ______ Other __________
Subscriber's SS # or ID # : __________
Group #: __________

SECONDARY INSURANCE TO FILE

Insurance Company's Name: __________
Insurance Company's Address:__________
Subscriber's Name:__________ Birthdate:__________
Relationship to Patient: Self ______ Spouse ______ Parent or Guardian ______ Other __________
Subscriber's SS # or ID #: __________
Group #: __________

PATIENTS WITH INSURANCE OTHER THAN MEDICARE

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I am financially responsible for non-covered services, deductibles, and/or co-payments.

Signature: ______________________________ Date __________

MEDICARE PATIENTS

I request that payment of authorized medical benefits be made either to me or on behalf of the provider named above for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: ______________________________ Date : __________

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