

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:

Prescription Medications, please list

Over the Counter Medications, please list:
(Pain Relief, Laxatives, Vitamins, Herbs)

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

- 1 _____
- 2 _____
- 3 _____
- 4 _____

REVIEW OF SYSTEMS

(Constitutional)

- ___ weight loss
- ___ fevers
- ___ night sweats
- ___ fatigue

(Eyes)

- ___ cataracts
- ___ blurry vision
- ___ glaucoma

(Ears)

- ___ ringing in ears
- ___ hearing loss

(Cardiovascular)

- ___ heart disease
- ___ heart murmur
- ___ high blood pressure
- ___ chest pain

(Respiratory)

- ___ shortness of breath
- ___ tuberculosis
- ___ hay fever
- ___ sinusitis
- ___ cough
- ___ asthma

(Gastrointestinal)

- ___ abdominal pain
- ___ jaundice
- ___ bloody stool
- ___ hepatitis
- ___ ulcer

(Genitourinary)

- ___ frequent urination
- ___ sexually transmitted disease

(Musculoskeletal)

- ___ joint pain
- ___ muscle weakness
- ___ lupus

(Skin)

- ___ eczema
- ___ psoriasis
- ___ itching
- ___ bruise easily
- ___ keloids
- ___ frequent sun exposure
- ___ skin cancer; type _____
- ___ abnormal mole
- ___ difficulty healing
- ___ hives
- ___ hair loss
- ___ lupus

(Neurologic)

- ___ seizures
- ___ dizziness
- ___ headaches

(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. _____ Karen Riggs, M.D. _____

In the event of an emergency please notify: Name _____ Phone # (____) _____

Relationship _____ Date _____

DERMATOLOGY, LTD.
PATIENT INFORMATION
PLEASE COMPLETE BOTH SIDES

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 /PART-TIME
STUDENT STUDENT

DATE OF BIRTH: _____ AGE: _____ SEX: _____ SS #: _____

Home Phone # () _____ Work Phone # () _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Employer's/School's Name: _____

Employer's/School's Address: _____

RESPONSIBLE PARTY INFORMATION - CIRCLE: PARENT SPOUSE GUARDIAN

Name: _____ SS #: _____

Street Address: _____

Mailing Address: _____

Email Address: _____

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: _____