DERMATOLOGY FOR THE FAMILY

PATIENT INFORMATION - ALL ITEMS MUST BE FILLED IN COMPLETELY

Today's Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ Date of Birth: _____ Age: ____ Sex: M F Other

City, State, Zip: _____ **Circle One:** Single • Married • Widowed • Divorced • Domestic Partnership

Employed By: _____ Home Phone: _____

Occupation: _____ Cell Phone: _____

Referred By: _____ Work Phone: _____ Ext. _____

Email Address: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP _____ **PHONE NUMBER** _____

INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship to Policy Holder: _____

Sex: M F Other Date of Birth: _____

Primary Insurance Co: _____ ID # _____ Group # _____

Secondary Insurance Co: _____ ID # _____ Group # _____

RACE
- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian/Other Pacific Islander
- White
- Unknown/Other

ETHNICITY
- Not Hispanic or Latino
- Hispanic or Latino

PREFERRED LANGUAGE
- English
- Spanish
- Other: _____

SMOKING STATUS
- Never Smoked
- Current Smoker
- Former Smoker

ALCOHOL STATUS
- Do not drink
- Drink socially
- One or more drinks daily

WE ALSO OFFER:

☐ Botox ☐ Laser

☐ Fillers ☐ Peels

☐ Rejuvapen

Check box if interested

HEIGHT _____ inches **WEIGHT** _____ lbs

COVID-19 VACCINE _____ **Yes** _____ **No**

DO YOU TAKE ANY MEDICATIONS, HERBAL SUPPLEMENTS, OR MULTIVITAMINS? ( ) No ( ) If Yes, please list name, dosage & frequency:

_____

_____

DRUG ALLERGIES No Yes (please circle or list): Aspirin, Codeine, Penicillin, Sulfa, Other: _____

CURRENT PROBLEM (please circle or describe your main problem):

Acne, Eczema, Psoriasis, Rosacea, Poison Ivy, Warts, Other: _____

DO YOU HAVE A HISTORY OF (please circle): AIDS, Arthritis, Asthma, Bleeding Problems, Cancer, C-diff, Colitis, Diabetes, Eczema, Excessive Sweating, Hay Fever, Heart Disease, Hepatitis B/C, Hidradenitis Suppurativa, High Blood Pressure, High Cholesterol, HIV, Irregular Periods, Kidney Disease, MRSA, Psoriasis, Rosacea, Thyroid Disorder, Tuberculosis, Ulcers, Warts **NONE**

YOUR PRIMARY CARE PHYSICIAN (PCP) _____

YOUR PHARMACY _____ **ADDRESS/TELEPHONE:** _____

1) **I authorize the release of any medical or other information necessary to process this claim. I also request payment of government (or other health insurance) benefits either to myself or to the party who accepts assignment.**
2) **Medication History Consent: I authorize consent to obtain my medication history from my pharmacy(s).**
3) **I authorize information regarding my care to be provided through text message or voicemail message on my cell, home or work phone, or emailed to me.**
4) **I understand that I am responsible for any balance not covered by insurance. A current credit card will be kept on file and will be automatically drafted for any outstanding balance for all members on your policy.**
5) **There will be a $50.00 charge for appointments cancelled or missed without 48 hours advance notice. Also, if you have 3 or more cancelled or missed appointments, we reserve the right to dismiss you from our practice.**

Patient or authorized person's signature: _____ Physician's Review _____

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