## DERMATOLOGY FOR THE FAMILY

Employed By:	PATIENT INFORMATION - ALL IT			Foday's Date:
City, State, Zip:				
Employed By:	City, State, Zip:			_
Cell Phone:			Home Phone:	
Relationship  Relationship  PHONE NUMBER  Relationship Declicy Holder:  Sex: M F Other  Date of Birit:  Final Address:  Relationship Declicy Holder:  Sex: M F Other  Date of Birit:  Final Relationship Declicy Holder:  Secondary Insurance Co:  ID # Group #  Relationship Declicy Holder:  Secondary Insurance Co:  ID # Group #  RACE  RACE  ETHIOLITY  SMOKING STATUS  American Indian/Alaskan Native Asian Address Hapanic or Latino Hapanic or Latino Hapanic or Latino Asian Declicy Holder:  RACE  Final Group #  RELATIONSHIP  REPAIR OF LATINO  American Indian/Alaskan Native Asian Pavalian/Other Pacific Islander PREFEID LANGUAGE Alace Declicy Hapanic or Latino Hapanic or Latino Declicy Hapanic or Latino Hapanic or Latino Declicy Hapanic or Latino Hapanic or Latino Declicy Hapanic or Latino Declicy Hapanic or Latino Declicy Hapanic Market Mayor M				
EMERGENCY CONTACT NAME:    RELATIONSHIP	•	_		
ERLATIONSHIP PHONE NUMBER   PHONE NUMBER	,			
RELATIONSHIP	EMERGENCY CONTACT NAME:			
Policy Holder's Name:				
Secondary Insurance Co:	INSURANCE INFORMATION		<u> </u>	
Primary Insurance Co:	Policy Holder's Name:		Relationship to Policy Holder: _	
RACE  American Indian/Alaskan Native Asian Alian	Sex: M F Other	Date of	Birth:	<u> </u>
American Indian/Alaskan Native Asian Black or African American Black o	Primary Insurance Co:	ID #		Group #
American Indian/Alaskan Native Asian	Secondary Insurance Co:	ID#		Group #
American Indian/Alaskan Native Asian				
American Indian/Alaskan Native Asian	RACE	ETHNICITY	SMOKING STATUS	
Black or African American Native Hawaiian/Other Pacific Islander White Unknown/Other    PREFERED LANGUAGE	American Indian/Alaskan Native	•		
Native Hawaiian/Other Pacific Islander White  Unknown/Other    PREFERED LANGUAGE   English   Spanish   One or more drinks daily		Hispanic or Latino		WE ALSO DEEER:
Unknown/Other    English   Do not drink   Drink socially   One or more drinks daily   Fillers   Peels   Peels   One or more drinks daily   Peels   Rejuvapen	Native Hawaiian/Other Pacific Islander	PREFERRED LANGUAGE		
Spanish Other: Other: One or more drinks daily    Rejuvapen		•		
Rejuvapen		•	,	☐ Fillers ☐ Peels
COVID-19 VACCINE		Other	,	□ Rejuvapen
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 Diseas  MRSA, Psoriasis, Rosacea, Thyroid Disorder, Tuberculosis, Ulcers, Warts NONE  YOUR PRIMARY CARE PHYSICIAN (PCP)  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	<u>HEIGHT</u> inches	WEIGHT	bs	Check box if interested
DRUG ALLERGIES No Yes (please circle or list): Aspirin, Codeine, Penicillin, Sulfa, Other:	COVID-19 VACCINEYes	No		
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Patient or authorized person's signature:

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Physician's Review \_\_\_\_\_