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: (please circle) M F

City, State, Zip: ______________________ Marital Status: S M W D Soc. Sec. # ______________________

Employed By: ______________________ Home Phone: ______________________

Occupation: ______________________ Cell Phone: ______________________

Referred By: ______________________ Work Phone: ______________________ Ext. __________

If Minor, Parent or Guardian Name: ______________________ Email Address: ______________________

YES I ______________________ authorize treatment for my minor child if I am not physically present

EMERGENCY CONTACT NAME: ______________________

RELATIONSHIP ______________________ **PHONE NUMBER** ______________________

INSURANCE INFORMATION

Policy Holder's Name ______________________ Sex (please circle) M F Date of Birth ______________ Soc. Sec. # ______________

Relationship to Policy Holder ______________________

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

AESTHETIC PROCEDURES

If interested, please circle:

Botox **Laser**
Fillers **Peels**
Rejuvapen

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

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____

____

HEIGHT ______________ inches WEIGHT ______________ lbs

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, Poison Ivy, Warts, Other: ______________________

DO YOU HAVE A HISTORY OF **(please circle):** Arthritis, Asthma, Bleeding Problems, Cancer, C-diff, Colitis, Diabetes, Eczema, Hay Fever, Heart Disease, Hepatitis B/C, High Blood Pressure, HIV, Irregular Periods, Kidney Disease, MRSA, Psoriasis, Thyroid Disorder, Tuberculosis, Ulcers

YOUR PRIMARY CARE PHYSICIAN (PCP) ______________________ Telephone ______________

YOUR PHARMACY ______________________ 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 voice mail message on my cell, home or work phone, or emailed to me.**
4) **I understand that I am responsible for any amounts (deductible, copayment, or other noncovered items) as determined by my insurance carrier.**
5) **There will be a $50.00 charge for appointments cancelled or missed without 24 hours advance notice.**
6) **I understand that non-payment of an outstanding balance may be reported to a credit bureau/agency for further action.**

Patient or authorized person's signature: ______________________ Physician's Review ________

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