PATIENT INFORMATION

(PLEASE PRINT)

Name _____ Nick Name _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Driver's License# _____ Social Security# _____

Occupation _____ Employer _____

Employer Address _____ City _____ ST _____ Zip _____

Emergency Contact Name _____ Phone# _____

Insurance Name _____ Policy# _____ Group# _____

Secondary Insurance _____

RESPONSIBLE PARTY (This is the insurance policy holder; skip this section if policy holder is same as patient)

Name _____ Relationship to patient _____

Address _____ Phone _____

Date of Birth _____ Driver's License# _____ Social Security#_____

HEALTH INFORMATION

1. What medical conditions do you have? _____

_____

2. What medications are you taking? _____

_____

3. List medications you are allergic to: _____

_____

4. Do you have now, or have you ever had any of the following?

Heart attack: Yes ___ No ___ Stroke: Yes ___ No ___ Trouble breathing: Yes ___ No ___

High blood pressure: Yes ___ No ___ Seizures: Yes ___ No ___ Blood clots: Yes ___ No ___

Hepatitis: Yes ___ No ___ HIV/AIDS: Yes ___ No ___ Bleeding disorder: Yes ___ No ___

Abnormal scarring: Yes ___ No ___ Skin cancer: Yes ___ No ___ Family history of melanoma:Yes ___ No ___

5. Are you pregnant or plan on becoming pregnant? _____

6. What skin conditions have you been diagnosed with? _____

_____

7. May we leave appointment information or test results on your answering machine or voice mail? _____

Primary Care physician's name & phone# _____

Name of other family members seen as patients _____

How did you hear about us? _____