



*Pediatric, Adult & Geriatric Dermatology
Cosmetic Surgery & Skin Care Rejuvenation Center*

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Diplomate, American Board of Dermatology

GENERAL

Today's Date _____

PATIENT'S NAME _____ BIRTHDATE _____

SOCIAL SECURITY # _____ MARITAL STATUS _____ SEX: MALE _____ FEMALE _____

ADDRESS _____ CITY _____ ZIP CODE _____

HOME PHONE () _____ WORK PHONE () _____

OCCUPATION _____ CELL # () _____

E-MAIL ADDRESS _____

INSURANCE

REFERRING PHYSICIAN _____ COPAY AMOUNT \$ _____
CO-INSURANCE AMOUNT \$ _____
DEDUCTIBLE AMOUNT \$ _____

PRIMARY INSURANCE CO _____ POLICY/GROUP # _____
POLICY HOLDER'S NAME _____ POLICY HOLDER'S BIRTHDATE _____ POLICY HOLDER'S SS # _____

SECONDARY INSURANCE CO _____ POLICY/GROUP # _____
POLICYHOLDER'S NAME _____ POLICYHOLDER'S BIRTHDATE _____ POLICYHOLDER'S SS # _____

MEDICAL

LIST ALL ALLERGIES TO MEDICATIONS OR SUBSTANCES _____

LIST ALL MEDICATIONS, VITAMINS, OTC PREPARATIONS, OR RECREATIONAL DRUGS YOU
ARE CURRENTLY TAKING _____

IF YOU REQUIRE ANTIBIOTICS PRIOR TO SURGICAL / DENTAL PROCEDURES, PLEASE
EXPLAIN _____

PERSONAL CURRENT / PAST HEALTH PROBLEMS: (If yes, please explain)

Cancer	YES	NO	_____	Eyes	YES	NO	_____
Ears/Nose/Throat/Mouth	YES	NO	_____	Heart	YES	NO	_____
High Blood Pressure	YES	NO	_____	Liver Disease	YES	NO	_____
Lungs	YES	NO	_____	Stomach/Bowel	YES	NO	_____
Arthritis/Muscles/Joints	YES	NO	_____	Kidneys	YES	NO	_____
Headaches/Seizures	YES	NO	_____	Bleeding Disorder	YES	NO	_____
Psychological Disorder	YES	NO	_____	Allergic/Immunologic	YES	NO	_____
Venereal Disease	YES	NO	_____	Other (i.e. Diabetes, Lupus, Etc.)	YES	NO	_____

MEDICAL HISTORY:

	SELF	MOTHER	FATHER	BLOOD RELATIVE	EXPLANATION
Allergies	—	—	—	—	_____
Asthma	—	—	—	—	_____
Diabetes	—	—	—	—	_____
Eczema	—	—	—	—	_____
Malignant melanoma	—	—	—	—	_____
Psoriasis	—	—	—	—	_____
Skin cancer	—	—	—	—	_____
Other Skin Conditions	—	—	—	—	_____

TO BE COMPLETED BY ALL WOMEN:

Are you pregnant or nursing? YES NO
 Are you currently planning a pregnancy? YES NO
 Are you taking birth control pills? YES NO

Please inform the doctor at any time if you become pregnant during treatment.

FINANCIAL

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

REFERRAL REQUIREMENT

If your insurance plan requires you to obtain a referral from your primary care physician for you to use our specialty healthcare providers, you must bring us a valid, unexpired referral. Without such referral, your insurance company will not permit our specialists to examine and/or treat you. **If you need a referral but do not have one and still desire to be examined and/or treated, you will be charged for such service(s).**

ASSIGNMENT OF BENEFITS

I authorize payment of Medicare or any other commercial medical insurance benefits on my behalf to Dermatique or its employees for professional services rendered.

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____
 (Patient, Parent/Guardian if Minor/Incompetent)

Physician's Signature _____ Date _____