Northeast Dermatology/Skin Dermatology

OFFICE USE ONLY
INITIALS:_____

PATIENT DEMOGRAPHIC INFORMATION

PLEASE COMPLETE THIS ENTIRE FORM. THANK YOU!

TODAY'S DATE: ___/___/___

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH: (MM/DD/YYYY)

MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

PRIMARY PHONE: - - ☐ Home ☐ Work ☐ Cell	**SECONDARY PHONE:** - - ☐ Home ☐ Work ☐ Cell	EMAIL ADDRESS:

MAY WE LEAVE A DETAILED MESSAGES ON YOUR PRIMARY PHONE? ☐ YES ☐ NO	SSN:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED	GENDER: ☐ MALE ☐ FEMALE

PRIMARY CARE PHYSICIAN: PHONE NUMBER:	PHARMACY NAME: PHONE NUMBER:

WERE YOU REFERRED TO OUR OFFICE? ☐ PHYSICIAN (IF YES) PHYSICIAN NAME:
☐ WEB SEARCH ☐ FAMILY MEMBER ☐ FRIEND ☐ NEWSPAPER AD ☐ FACEBOOK

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	PHONE NUMBER:	RELATIONSHIP:

MAY WE DISCLOSE MEDICAL/BILLING INFORMATION TO THIS INDIVIDUAL? ☐ YES ☐ NO	IF NOT, WITH WHOM MAY WE DISCUSS YOUR MEDICAL/BILLING INFORMATION?

EMPLOYER INFORMATION

EMPLOYER NAME:	OCCUPATION:

INSURANCE INFORMATION

I HAVE INSURANCE: ☐ YES ☐ NO (SELF PAY)

PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:		SUBSCRIBER:	
RELATION:	GENDER: ☐ MALE ☐ FEMALE	RELATION:	GENDER: ☐ MALE ☐ FEMALE
DATE OF BIRTH:	SSN:	DATE OF BIRTH:	SSN:

ADVANCED DIRECTIVES

(IF YES, *PLEASE PROVIDE A COPY TO THE FRONT DESK*)

DO YOU HAVE A LIVING WILL? ☐ NO ☐ YES
DO YOU HAVE A DO NOT RESCUSITATE? ☐ NO ☐ YES

DO YOU HAVE A DURABLE POWER OF ATTORNEY? ☐ NO ☐ YES
LAST NAME: FIRST NAME: PHONE NUMBER:

Reason for visit: _____

Medications: OR attach a medication list to this form.

_____

_____

_____

Allergies to medications:

_____

_____

Surgical history: _____

Smoking status: NEVER FORMER CURRENT Alcohol intake: less than 1 per day 1-2 per day 3 or more per day

Have you been vaccinated for pneumonia? YES NO

Have you been vaccinated for the FLU this latest FLU season? YES NO

Medical History

☐ None
☐ Anxiety (disorder)
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Arteriosclerosis/hardening arteries
☐ BPH/enlarged prostate
☐ Cancer Type: _____
☐ COPD/Lung disease
☐ Depressive (disorder)
☐ Diabetes mellitus
☐ End stage renal disease/kidney disease
☐ Epilepsy/seizures
☐ GERD/acid reflux
☐ Heart failure
☐ Hearing loss
☐ Hypertension/high blood pressure
☐ Hypercholesterolemia/high cholesterol
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Inflammatory liver disease/liver disease
☐ Leukemia
☐ Lymphoma
☐ Malignant tumor of breast
☐ Malignant tumor of colon
☐ Malignant tumor of lung
☐ Osteoporosis
☐ Radiation treatment
☐ Transplant of bone marrow
☐ Tumor of prostate
☐ Other: _____

Skin Medical History

☐ Acne
☐ Eczema
☐ Psoriasis
☐ Hay fever/allergies
☐ Dysplastic moles or atypical moles
☐ Actinic Keratosis
☐ Basal cell carcinoma
☐ Squamous cell carcinoma
☐ Melanoma Date: _____ Location: _____
☐ Family history of malignant melanoma Relation: _____

Review of Systems

☐ Are you pregnant
☐ Planning on pregnancy
☐ Breastfeeding
☐ Latex allergy
☐ Allergy to epinephrine
☐ HIV/AIDS
☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Problems with local anesthetic
☐ Allergy to topical antibiotics
☐ **ARTIFICIAL HEART VALVE**
☐ **ARTIFICIAL JOINTS IN PAST 2 YEARS**
☐ **BLOOD THINNERS**
☐ Implanted defibrillator
☐ MRSA
☐ **PACEMAKER**
☐ **PREMEDICATION PRIOR TO PROCEDURE**
☐ Rapid heartbeat with Epinephrine
☐ Changing moles
☐ Bleeding problems
☐ Problems with healing
☐ Problems with Scarring