

**Please Read and Complete All Spaces on This Form**

**PATIENT INFORMATION**

(Please Print)

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
*Last First MI Occupation*

Mailing Address \_\_\_\_\_  
*Apt City St Zip*

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN \_\_\_\_\_  
*Area Code Area Code*

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Marital Status \_\_\_\_ Cell Ph# \_\_\_\_  
*MM DD YYYY M/S/D Area Code*

Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Work Ph# \_\_\_\_\_  
*Area Code*

Relationship of Patient to Policy Holder: \_\_\_\_\_ (Self / Spouse / Child / Other)

**POLICY HOLDER / SUBSCRIBER (To Receive Billing Statement)**

Name \_\_\_\_\_  
*Last First MI Employer*

Mailing Address \_\_\_\_\_  
*Apt City St Zip*

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN \_\_\_\_\_  
*Area Code Area Code*

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Marital Status \_\_\_\_ Cell Ph# \_\_\_\_  
*MM DD YYYY M/S/D Area Code*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Primary Insurance Carrier (Present Card To Receptionist) Subscriber ID# Group Number**

**SECONDARY INSURANCE INFORMATION (Please present insurance card to receptionist)**

\_\_\_\_\_  
**Insurance Carrier Address City State Zip**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Name Of Subscriber to Insurance Date of Birth Subscriber ID# Plan Group Number**  
*(IE Spouse/Parent/Self)*

\_\_\_\_\_  
**Employer's Name Employer's City and State Patient's Relationship to Insured**

In case of **EMERGENCY**, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referred By \_\_\_\_\_

I authorize my insurance carrier to make payment directly to my physician for services rendered.

Patient or Policy Holder Signature \_\_\_\_\_ Date \_\_\_\_\_

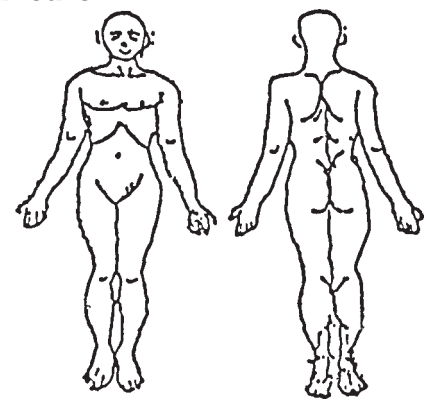
## Brief Medical History

– To provide you with more effective medical care –

A. What is your skin problem (rash, growths, warts, etc.)?  
\_\_\_\_\_

B. When did you first notice this skin problem?  
\_\_\_\_\_

C. Please draw on the diagram at right indicating where your present skin problem or rash is by marking X's on the figures.



PLEASE CIRCLE YES OR NO AND ANSWER THE FOLLOWING:

- |  |     |    |
|--|-----|----|
| <p>1. Have you had any other skin problems?<br/>If yes, please list: _____</p>   | YES | NO |
| <p>2. Has anyone in your family had malignant melanoma or abnormal moles?</p>  | YES | NO |
| <p>3. Do you have any family history of skin problems, rashes or diseases?</p>   | YES | NO |
| <p>4. Has a doctor given you anything for your skin for this problem?<br/>If yes, please give the names of everything used: _____<br/>_____</p>            | YES | NO |
| <p>5. Have you put anything else on your skin for this problem?<br/>If yes, please give the names of everything used: _____<br/>_____</p>                  | YES | NO |
| <p>6. Are you allergic to any medicines (penicillin, aspirin, etc.)?<br/>If yes, please list: _____</p>  | YES | NO |
| <p>7. Does anything touching your skin cause a rash or allergy (jewelry, poison oak, etc.)?<br/>If yes, please list: _____<br/>_____</p>                   | YES | NO |
| <p>8. Are you now being treated by a doctor?<br/>If yes, for what? _____</p>   | YES | NO |
| <p>9. Do you now have or have you ever had eczema, hives, easy bleeding or asthma?</p>   | YES | NO |
| <p>10. How is your general health?     <i>Circle one:</i>     Excellent     Good     Fair     Poor</p>   |     |    |
| <p>11. Please list all pills, medicines or tablets you are taking including non-prescription medications:<br/>_____</p>                                    |     |    |
| <p>12. Is there anything else I should know about your health? (such as recent surgery, diabetes, stomach ulcers, easy bleeding, etc.) _____<br/>_____</p> | YES | NO |
| <p>13. Have you had blistering sunburns?</p>   | YES | NO |