DERMATOLOGY, LASER SURGERY AND SKIN SURGERY-----BOARD CERTIFIED

Welcome to our office. Please fax completed form to **212.557.6065** or bring completed form to our office for your initial visit. Save a copy for your records in case the fax does not come through. For privacy reasons, please do not e-mail this form to us. Thank you.

PLEASE ANSWER THESE QUESTIONS, IN ORDER, SO WE MAY SERVE YOU BETTER. PRINT AND RETURN. YOU MAY USE THE BACK OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED. ALL MEDICAL INFORMATION IS CONFIDENTIAL.

Name Ms. / Mrs. / Mr.______________________________________ Birthdate____/____/____ Age____ Today's Date____/____/____
First Middle Initial Last

Street Address________________________________Apt #________City__________________State______Zip____________

Occupation______________________________________Employer____

Business Address______________________________________City______________________State______Zip____________

Social Security #________-_________-________ Email Address____

Home Telephone #: (_____) _________________ Work #: (_____)__________________ Cell #:(_____)__________________

Circle one: Single/Married/Divorced/Separated/Widowed Spouse/Partner's Name:_____________________________________

In an emergency contact____
Name Work Phone Home Phone Relation

Referred by (circle or give name if known): Doctor____________________________; Patient____________________________;
Yellow Pages; White Pages; or Internet (specify site)____

MEDICAL/DERMATOLOGIC HISTORY

Do you or have you: (please circle)

Burn easily when exposed to the sun?………………Yes/No
Had any sunburns that blistered?……………………Yes/No
Often go without sunscreen when sun exposed?…….Yes/No
Ever worked outdoors?………………………………Yes/No
Been under additional stress lately?…………………Yes/No
Smoke regularly……………………………………..Yes/No
Exercise infrequently?……………………………….Yes/No
Eat an unbalanced diet?…………………………….. Yes/No

Do You or Does Anyone in Your Family:

Have asthma, eczema, hayfever, or hives?…………..Yes/No
Have psoriasis?………………………………………Yes/No

Do You or Does Anyone in Your Family:

Have unusual appearing or numerous moles?……..…Yes/No
If so, whom?____________________________________
Have skin cancer?…………………………………..…Yes/No
If so, which kind and whom, if known?______________

If Male, please skip this section --- For Women Only

Do you have irregular/absent menstrual cycles?…..…Yes/No
Are you on the birth control pill?………………….... Yes/No
Have you had any vaginal yeast infections?……….... Yes/No
Are you planning a pregnancy?……………………....Yes/No
Are you pregnant?…………………………………..…Yes/No
Are you currently breastfeeding?…...………………..Yes/No

Please inform the doctor immediately if you plan To become pregnant during your treatment.

1.Describe any recent travel ____________________________________ Hobbies______________________________________
2.How long have you had this skin problem?______________________ Any prior treatment and what kind?________________
3.Have you had other skin disorders? How were they treated?____
4.Do you have difficulty with healing of wounds, keloids, or overgrown scars?_______________________________________
5.If you take medication, vitamins, drugs, over-the-counter (non-prescription) preparations, please list with dosages, if known:____
____
6.If you have had an allergic reaction to medications, anesthetics or epinephrine, please list:__________________________________
7.If you are currently in the care of an internist, GP or gynecologist; please list:_______________________________________
8.Any other information you feel will be helpful____
9.Are you interested in ways to rejuvenate your skin and maintain a youthful appearance?_____________________________
10.Would you like to receive our Practice E-Newsletter to learn about dermatology advances and promotions? Yes___No___
(If you leave #10 unchecked we will assume yes.)

Your Signature:____ Date______________________________

MEDICAL INSURANCE INFORMATION

Do you have Medicare? Yes_____ No_____
Insurance company name and address____
Who is the subscriber? (name on insurance ID care or name of policy holder)____
Policy (certificate ID#)_________________ Group name(if applicable)________________________ Group #_______________
Additional insurance: company name, address, policy #, etc.____
Does your insurance cover prescriptions? YES, I have a card______; YES, I get reimbursed_____; No_____; Do not know_______
Who is financially responsible for today's bill?_______________; Payment will be made in: Cash____ Check___ Credit Card_____

Assignment of Benefits/Release of Information

I authorize the release of any medical information necessary to process this claim and I authorize payment of medical benefits to the named provider for professional services rendered.

Your Signature:____Date__________________________________