Medicare Muir NetSelect Hill UHC Aetna HealthNet Cigna BlueCross BlueShield Other Private/Cosmetic

MR#_____ Date _____ Insurance Change? Y / N

Patient Name: _____ **Last 4 of SSN**: _____

Pharmacy (name, city, street): _____

Referring Physician: _____ **Do you smoke**? Y / N

_____ _____ __M / F__ _____

Date of Birth **Age** **Sex** **Email**

Has your Insurance changed since your last visit? Y / N

<u>If you have not filled out this form before or you have changes please provide the following</u>

What is your primary Language (check one): □ English □Spanish □ Other:_____

Ethnicity (check one): □ Hispanic/Latino □ Not Hispanic/Latino □ Unknown □ Declined to Specify

Race (check one): □ American Indian or Alaska Native □ Asian □ Black or African American

□ Native Hawaiian or other Pacific Islander □ White □ Other Race □ Declined to Specify

PATIENT INFORMATION - PLEASE PRINT

Circle one: Mr. - Mrs. - Miss - Ms. - Dr. - Hon.

Circle one: Married/Partner - Significant Other - Separated - Single - Divorced - Widow

Phone (Home): _____

Phone (work/cell): _____

Address: _____

Number Street Apt. City State Zip

Has this office ever treatment a member of your family? _____

Name

INSURANCE POLICY HOLDER AND GUARDIAN INFORMATION

Policy Holder Name: _____ Birth Date: _____

Policy Holder Address: _____

Number Street Apt. City State Zip

Phone (Home): _____

Phone (work/other): _____

What brings you in today? What are your skin concerns?

Medication List _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (hives, rash, anaphylaxis, *medications, Band-Aids, tape, antibiotic ointment or other*)

Past Medical History Now or in the past do you have any of the following?

Poor or slow healing yes/no Develops keloids yes/no Aphthous Ulcers yes/no Herpes yes/no

Asthma or Hayfever yes/no Excessive Bleeding yes/no Arthritis/joint pain yes/no Joint Replacement yes/no

Kidney Problems yes/no Pacemaker/defibrillator yes/no Heart Disease or Murmur yes/no Stroke yes/no

Vision problems yes/no Nervous/Anxiety Disorder yes/no Lupus yes/no Nausea from antibiotics yes/no

Thyroid problems yes/no Cancer yes/no High Blood Pressure yes/no Diabetes yes/no

Transfusions yes/no Stomach ulcers yes/no Leg swelling yes/no Headaches yes/no

Hepatitis B or C yes/no HIV yes/no Syphilis yes/no Tuberculosis yes/no

Other**:**

Skin Disease History (eg, Melanoma, Basal cell carcinoma, eczema, psoriasis, other)

Social History

Occupation _____ Pets_____

Children: yes/no Ages?_____ Recent Foreign Travel? _____

Alcohol Use: never previously, but quit rarely social moderate daily

Family History (eg, Melanoma, eczema, psoriasis)