

Welcome to Deerfield Dermatology Associates, Ltd.

Date: _____

PLEASE PRINT

PATIENT INFORMATION

Patient Name: _____ Last Name First Name Middle Initial SS # _____ / _____ / _____

Birthdate: _____ / _____ / _____ Age: _____ Male Female Marital Status: Married Single other

Preferred language: _____ Race: White Black Asian Latino Ethnic Background: _____

Address: _____ City State Zip

Billing address: (if different from mailing address) _____ City State Zip

Employed by: _____ Occupation: _____

Any other Family member or friend we have seen as a patient? _____

IN CASE THE DOCTOR NEEDS TO REACH YOU

Home phone: (_____) _____ - _____ May we call your home? Yes No May we leave a message at home? Yes No

Work phone: (_____) _____ - _____ May we call your work? Yes No May we leave a message at work?: Yes No

Cell phone: (_____) _____ - _____ May we call your cell? Yes No May we leave a message on your cell? Yes No

May we leave messages with members of your household? Yes No Who may we leave message with? _____

email address: _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

If same as patient, write: "Same"

_____ Last Name First Name Middle Initial SS # _____ / _____ / _____

Relationship to patient: _____ Birthdate: _____ / _____ / _____ Marital Status: Married Single other

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)

Primary insurance: _____ Secondary Insurance: _____

PERSONAL MEDICAL HISTORY

Please check YES or NO for conditions you have or have had in the past.

- Y N Personal history of skin cancer Type: Date:
Y N Family history of psoriasis
Y N History of skin disease
Y N AIDS
Y N Allergic to local anesthetic
Y N Epilepsy
Y N Lung Disease
Y N Personal history of melanoma Type: Date:
Y N History of cold sores
Y N Anemia
Y N Gout
Y N Multiple Sclerosis
Y N Family history of skin cancer Type: Date:
Y N History of genital herpes
Y N Bleeding disorder
Y N Heart surgery
Y N Prostate Problems
Y N Asthma
Y N Blood transfusion
Y N Hepatitis
Y N Rheumatic Fever
Y N Eczema
Y N Cancer
Y N Herpes
Y N Stroke
Y N Family history of melanoma Type: Date:
Y N Food Allergies Type:
Y N High Blood Pressure
Y N Tuberculosis
Y N Hives/Urticaria
Y N Cataracts
Y N High Cholesterol
Y N Ulcers
Y N Jewelry/Nickel Allergy
Y N Chemical dependency
Y N HIV Positive
Y N Venereal Disease
Y N Family history of eczema
Y N Latex Allergy
Y N Chicken Pox
Y N Joint replacement
Y N Tobacco use qty:
Y N Family history of asthma
Y N Seasonal Allergies
Y N Colitis-diarrhea
Y N Kidney Disease
Y N Alcohol use qty:
Y N Family history of seasonal allergies
Y N Photosensitivity
Y N Diabetes
Y N Liver Disease
Y N Other: _____

CURRENT MEDICATIONS: NONE or list _____

PLEASE LIST ALL MEDICATION ALLERGIES: NONE _____

PHARMACY NAME: _____ LOCATION: _____ PHONE NO.: _____

Please tell us how you heard about us: Friend Family Member Doctor's referral Yellow pages Internet Other

Physician who referred you _____ Name of General Internist (if different) _____

