ESTERSON DERMATOLOGY

PATIENT DEMOGRAPHICS

Last Name:_____________________________ First Name:____________________________

Date of Birth:_________ Age:_________ Sex: __Female __Male Race:__________________________

Ethnicity: Hispanic:_____ or Non-Hispanic:_________ Preferred Language:____________________

CONTACT

Address:____

City:_____________________________________ State:______________________________ Zip:_____________________________________

Home:___________________________________ Work:______________________________________ Cell:__________________________

May we email you for specials, promotions, etc? __YES __NO Email:____

REFERRAL

How did you hear about us? (If physician/friend, please list name)

____
_

EMPLOYMENT

Employer:____

Occupation:____

EMERGENCY CONTACT

Last Name:___________________ First Name:___________________ Relationship to Patient:________________Ph. Number:__________

INSURANCE INFORMATION

Primary Insurance:______________________________________ ID#_________________________________ Group #______________________

Secondary Insurance:___________________________________ ID#__________________________________Group #______________________

FINANCIALLY RESPONSIBLE PARTY **(Complete if NOT SELF/Patient is a MINOR/NOT the main policy holder.)**

Last Name:_____________________________ First Name:_____________________ Relationship to Patient:__________________________

Date of Birth:____________________ Address:_____________________________________ Phone Number:_____________________________

PRIMARY PHYSICIAN

Physician Name:_______________________________________ Physician Phone Number:____

PREFERRED PHARMACY

Pharmacy Name:_______________________ Address:____________________________ Phone Number:_________________

Signature____
Date:____

Reason for Today's Visit:____

MEDICAL HISTORY (please check all that apply)

Medical Contions	Medication (s)
Anxiety	
Arthritis	
Asthma	
AIDS/HIV	
Blood Clots	
Cold Sores/Herpes	
Depression	
Diabetes	
Hepatitis; Type________________	
High Cholestrol	
Hypertenstion (high blood pressure)	
Hyperthyroidism	
Hypothyroidism	
Radiation Treatment or History	

OVER-THE-COUNTER MEDICATIONS, HERBALS, VITAMINS:____

PAST SURGERIES: (Please list all surgeries)____

SKIN CONDITION HISTORY (please check all that apply)

__Actinic Keratosis __Keloids **____NONE**

__Squamous Cell Cancer; Location______________________

__Melanoma; Location________________________________

__Precancerous Lesions; Location_______________________

__Basal Cell Cancer:Location____________________________

GENERAL SKIN QUESTIONS:

Wear Sunscreen, SPF:_________ History of Tanning Salon Use: __YES /__NO/ __CURRENT

Has a Relative Had Melanoma: __YES /__NO If yes, which relative(s):_____________________

CAUTIONS

__Difficulty Stopping Bleeding
__Artificial Joints:_______________
__Pacemaker/Defibrillator
__Antibiotic for Dental Procedures
__Artificial Heart Valve
__(**WOMEN**)Pregnant/ Trying/ Nursing

__Reaction to local anesthetic

ALLERGIES

Medication Allergies (please list):____ Latex Allergy: __YES/ __NO

SOCIAL HISTORY

Smoking History: _____ None _____Past History _____Currently Smokes
Alcohol Consuptions: _____ None _____Drinks 1-2/day _____Drinks 3 or more a day

I certify I have completed this form in its entirety, and the above is true and correct.Patient

Signature:____ Date:____________________