Boston Dermatology and Laser Center

Name: ______________________________

Date of Birth: ______________________________

Referred by: ______________________________

Primary Care Physician: ______________________________

Please describe the reason for your visit today: ______________________________

____

Have you ever experienced:	**In yourself?**		**In your family?**		**(Specify who)**
Skin Cancer	**Y**	**N**	**Y**	**N**	________
If yes, what type? ________					
Atypical/dysplastic moles	**Y**	**N**	**Y**	**N**	________
Psoriasis	**Y**	**N**	**Y**	**N**	________
Eczema	**Y**	**N**	**Y**	**N**	________
Seasonal allergies, hay fever, asthma	**Y**	**N**	**Y**	**N**	________
Difficulty with scarring or keloids	**Y**	**N**	**Y**	**N**	________
Difficulty with bleeding or clotting	**Y**	**N**	**Y**	**N**	________
Other cancer	**Y**	**N**	**Y**	**N**	________
Do you have a pacemaker or internal defibrillator?	**Y**	**N**			
Have you had joint replacement?	**Y**	**N**	If yes, when?		________
Have you had organ/bone marrow transplant?	**Y**	**N**	If yes, describe		________

Females:

Are you pregnant?	**Y**	**N**	If yes,
Are you trying to become pregnant?	**Y**	**N**	what is your
Are you nursing?	**Y**	**N**	due date? ________

Name ______________________________ Date of Birth __________

Past Medical History

Please check any of the following that apply to you

- ☐ High blood pressure
- ☐ Heart disease/arrhythmia
- ☐ Heart valve disease
- ☐ Diabetes
- ☐ History of cancer Type? ______________________________
- ☐ Asthma
- ☐ COPD/emphysema or other lung disease ______________________
- ☐ Thyroid or other endocrine disorder ______________________
- ☐ Autoimmune disorder
- ☐ Hematologic/blood disorder
- ☐ Arthritis/joint pain
- ☐ Kidney/Bladder disease
- ☐ Stomach ulcers/GERD or other gastrointestinal disorder (ie -Crohns, Ulcerative colitis)
- ☐ Liver disease/Hepatitis
- ☐ Infectious disease
- ☐ History of stroke
- ☐ Seizure disorder or other neurological disorders ______________________
- ☐ Psychiatric condition ______________________________
- ☐ Eye disease
- ☐ Hearing loss

Name ______________________ Date of Birth ____________

Social History

Marital Status: ____________ Occupation: ____________

Do you smoke/chew tobacco?	Y	N	If yes, how much? ____
Do you drink alcohol?	Y	N	If yes, how much? ____
Do you wear sunscreen?	Y	N	What SPF? ____
Have you ever used a tanning booth?	Y	N	
Do you currently use a tanning booth?	Y	N	If yes, how often? ____

Medications: *(PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER & SUPPLEMENTS)*

Allergies:

Surgical History

Boston Dermatology and Laser Center

PATIENT REGISTRATION

LAST NAME		FIRST NAME & INITIAL			
ADDRESS					
CITY		STATE		ZIP	
PATIENT'S S.S. NUMBER				HOME PHONE	
DATE OF BIRTH		GENDER		CELL PHONE	
EMPLOYER				WORK PHONE	
EMAIL ADDRESS				MARITAL STATUS (M/S	

PRIMARY CARE PHYSICIAN'S & PHARMACY INFORMATION

PCP'S NAME	
PCP'S PHONE NUMBER	
PREFERRED PHARMACY (name, street, city)	

INSURANCE INFORMATION

PRIMARY INSURANCE		ID NUMBER	
IF PATIENT IS NOT SUBSCRIBER / POLICY HOLDER PLEASE FILL OUT BELOW			
POLICY HOLDER'S LAST NAME		GROUP NUMBER	
POLICY HOLDER'S FIRST NAME		POLICY HOLDER'S RELATIONSHIP	
POLICY HOLDER'S DATE OF BIRTH		POLICY HOLDER'S GENDER	
IF APPLICABLE			
SECONDARY INSURANCE		ID NUMBER	
IF PATIENT IS NOT SUBSCRIBER / POLICY HOLDER PLEASE FILL OUT BELOW			
POLICY HOLDER'S LAST NAME		GROUP NUMBER	
POLICY HOLDER'S FIRST NAME		POLICY HOLDER'S RELATIONSHIP	
POLICY HOLDER'S DATE OF BIRTH		POLICY HOLDER'S GENDER	
SPOUSE'S NAME			

NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU

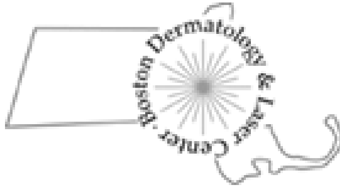
NAME		PHONE NUMBER	

YES, ________ By initaliling this line, you consent to receive text messages or emails to notify you of schedule updates, offers and events. (Only from Boston Dermatology & Laser Center, your information will not be given to any other party) I understand I always have the ability to opt-out if I decide I no longer want to receive these messages. To be removed from this list please contact the office and you be removed promptly.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the Physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.

I understand Boston Dermatology & Laser Center reserves the right to charge a fee for any scheduled visits that are cancelled with less than 24 hours notice or are missed without calling to cancel (no show)

SIGNATURE (PATIENT OR PARENT IF MINOR): X____ DATE: ____________________



Boston Dermatology & Laser Center

Acknowledgement of Receipt of Notice

I understand that Boston Dermatology & Laser Center may share and release my protected health information for treatment payment and healthcare operations as required by law.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

Signature: X___________________________________ Date: ______/______/______

Signature of Patient Representative: ____

Relationship of Patient Representative to Patient: _________________________________

Assignment of Benefits

I authorize direct payment of health insurance benefits to Boston Dermatology & Laser Center. I understand this assignment does not lessen my financial responsibility for any charges not covered by this authorization.

Signature: X___________________________________ Date: ______/______/______