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? ______

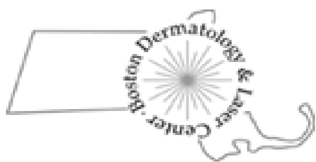
Have you ever used a tanning booth? Y N

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 ____________



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PATIENT REGISTRATION

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

PRIMARY CARE PHYSICIAN'S & PHARMACY INFORMATION

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

EMPLOYER'S INFORMATION

PATIENT'S EMPLOYER					
EMPLOYER'S ADDRESS					
CITY		STATE		ZIP	
EMPLOYER'S PHONE		POSITION			

INSURANCE INFORMATION (IF WE HAVE NOT SCANNED YOUR CARD)

INSURANCE #1		ID NUMBER	
POLICY HOLDER'S LAST NAME		GROUP NUMBER	
POLICY HOLDER'S FIRST NAME		RELATIONSHIP	
INSURANCE #2		ID NUMBER	
POLICY HOLDER'S LAST NAME		GROUP NUMBER	
POLICY HOLDER'S FIRST NAME		RELATIONSHIP	

SPOUSE'S NAME	
NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU	

AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

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.

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