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	
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	

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: _____