

image Dermatology ® P.C

51 Park Street, Montclair, New Jersey 07042

Date _____

PATIENT INFORMATION

Driver License Number: (REQUIRED) _____

Name: Last _____ First _____ Middle _____

Address _____ City, State, Zip _____

Phone: Home _____ Work _____ Ext _____

Cell Phone _____

Social Security# (REQUIRED) _____ Birth date _____

Sex: M F _____ Martial Status: Single Married Widow Divorced Separated

Occupation _____ Employer _____

Referred by _____ Address _____

Your Physician _____ Phone # _____

Your Pharmacy _____ Phone # _____

PRIMARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: _____ ID# _____ Group _____

Policyholder's Name: _____ Birth date: _____

Claim Mailing Address _____ Relation to patient: SELF, SPOUSE, DEPENDENT

SECONDARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: _____ ID# _____ Group _____

Policyholder's Name: _____ Birth date: _____

Claim Mailing Address _____ Relation to patient: SELF, SPOUSE, DEPENDENT

PATIENT HISTORY

Medications (including Aspirin and Birth Control Pills) _____

Drug Allergies _____

Do you require antibiotics before dental work? _____

FAMILY HISTORY

PERSONAL MEDICAL HISTORY (DID YOU EVER HAVE?)

Skin Cancer _____	Asthma	Y N	Keloids	Y N
	Hepatitis	Y N	Bleed Easily	Y N
	Pacemaker	Y N	Skin Cancer	Y N
	Diabetes	Y N	Melanoma	Y N
Melanoma _____	Ulcers	Y N	AIDS	Y N
	Hypertension	Y N	Risk Factors for Aids	Y N
Unusual Moles _____	Glaucoma	Y N	Mitral Valve Prolapse	Y N
	Tuberculosis	Y N	Cardiac Disease	Y N
	Liver Disease	Y N	Gastrointestinal Disease	Y N
	Kidney Disease	Y N	Arthritis	Y N
	Cancer	Y N	Psychiatric History	Y N

I authorize the release of my records to any referring physician or appropriate insurance company and medical information acquired in the course of my examination or treatment. If this account is referred to a collection agency for nonpayment, there will be an **additional 30%** fee added to the outstanding balance. I agree to pay a **\$35.00 cancellation fee** if I cancel or do not show up for my appointment with less than 48 hours notice.

Signature of Patient or Responsible party: _____