Brookline Dermatology Associates, PC - Patient Information

Name_____ Dr./Mr./Mrs./Ms. Date of Birth ____/____/____
Last First MI

Address_____ Apt #_____

City_____State_____Zip Code_____ SSN# ____-____-____

Home # (_____) _____-_____ Work # (____) _____-_____ Ext. _____ Cell # (____) _____-_____

I understand that I may have an obligation to obtain a referral from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have a required referral for today's visit, I am responsible for the services rendered should this be denied by my insurance company.

Date_____ Signature_____

_____

Primary Care Physician_____Phone # (___) _____-_____

Address _____

Referred by (if different than Primary Care Physician)_____

_____

Primary Insurance Information-Please fill in all information below

Medicare ____ Medex____ Tufts____ Blue Cross/Blue Shield____ Harvard Pilgrim____ Other Insurance____

(If "other insurance", please write name here)_____

Policy Number_____ Group Number_____ Phone # _____

Subscriber_____ If different from patient (Circle) Spouse Child Other

Secondary Insurance Information-Please complete all fields if applicable

Insurance Name_____ Address_____

Policy Number_____ Group_____ Phone#_____

Subscriber_____ If different from patient (Circle) Spouse Child Other

Consent to Treat and Payment Authorization

With my signature below, I voluntarily give consent for myself and/or my child to be examined and treated by the clinicians of ***Brookline Dermatology Associates, P.C.*** I also hereby assign and authorize payment of medical benefits. Payments may be made on my behalf directly to ***Brookline Dermatology Associates, P.C.*** for services rendered

Date____/____/____ Signature_____

Brookline Dermatology Associates, P.C.

Brookline Dermatology Associates, PC - Medical History and Intake Form

Name:_____ Date of Birth_____ Today's Date_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

NONE

Other_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other_____

Brookline Dermatology Associates, P.C.

Brookline Dermatology Associates, PC - Skin Disease History: (please circle all that apply)

Acne	**Eczema**	**Psoriasis**
Actinic Keratoses	**Flaking Or Itchy Scalp**	**Squamous Cell Skin Cancer**
Basal Cell Skin Cancer	**Hay Fever/Allergies**	**Melanoma**
Blistering Sunburns	**Poison Ivy**	**Precancerous Moles**
Dry Skin		

NONE

Other_____

Do you wear sunscreen? YES NO
If yes, what SPF?_____
Do you tan in a tanning salon: YES NO

Do you have a family history of Melanoma? YES NO
If yes, which relative(s)?_____

Medication: (Please list all current medications)
_____
_____
_____

Allergies: (Please list all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Currently Smokes-daily	**Never Smoked**
Currently Smokes-not daily	**Drug Use**
Has Smoked in the Past	

NONE

Other_____

What is your occupation?_____

Do we have permission to leave messages/results on voicemail? □ YES □NO
With immediate family members? □ YES □ NO

Brookline Dermatology Associates, P.C.

Brookline Dermatology Associates, PC - Review of Systems

Are you currently experiencing any of the following? (Please check YES or NO for the following)

Symptom	Yes	No
Pacemaker		
Defibrillator		
Artificial Joints		
Artificial Heart Valve		
Premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood Thinners		
Pregnancy or Planning a Pregnancy		
Allergy to lidocaine		
Rapid heartbeat with epinephrine		
Yeast infections with antibiotics		
GI upset with antibiotics		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
New or changing moles		
Rash		
Abdominal pain		
Anxiety		
Bloody stool		
Bloody urine		
Blurry vision		
Chest pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay fever		
Joint aches		
Muscle weakness		
Neck stiffness		
Seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional weight loss		
Wheezing		

Other Symptoms:_____

Brookline Dermatology Associates, P.C.