

# **Eastside Dermatology –New Patient Information**

**- PLEASE COMPLETE ALL SECTIONS OF THIS FORM -**

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_  
(First) (Middle Initial) (Last)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: M F

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

May we contact you via email if necessary? Y or N If yes, email address \_\_\_\_\_

If minor, Parent/Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral From:  Dr \_\_\_\_\_  Ad  Phone Book  Other \_\_\_\_\_

If referred by another doctor, their name & address \_\_\_\_\_

## **Insurance Information:**

Name of Primary Insurance Company: \_\_\_\_\_ Policyholder's ID #: \_\_\_\_\_

Policyholder's Name with Primary Insurance: \_\_\_\_\_ Policyholder's DOB: \_\_\_\_\_

Policyholder's Social Security #: \_\_\_\_\_ Patient's Relationship: \_\_\_\_\_

Do you have secondary insurance? Y or N Insurance: \_\_\_\_\_ Policyholder's ID #: \_\_\_\_\_

Secondary Policyholder's Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

*If you have secondary insurance coverage, please provide us with a copy of the card*

## **Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

May we leave medical information or test results on your voice mail at home? Y or N

May we discuss medical information or test results with family members? Y or N

If yes, Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

If patient is a minor, parent or guardian must sign to authorize treatment for minor.

Signature \_\_\_\_\_

Relationship \_\_\_\_\_

I hereby authorize release of information necessary to file a claim with my insurance company. I understand I am financially responsible for any balance not covered by my insurance carrier, and any collection/legal fees incurred for unpaid balances.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **Medicare Patients Only**

I request that payment of authorized medical benefits be made either to me on my behalf or to Eastside Dermatology Inc. for any services provided to me by their physicians. I authorize any holder of information about me to release to the Health Care Financing Administration and its agents, any information needed to determine benefits payable to related services.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE TURN OVER AND COMPLETE MEDICAL QUESTIONNAIRE.

**New Patient Health History**-In order to treat you safely & effectively, please answer the following questions. **This is for our records only & responses are confidential.**

**What problem brings you in today?** (Chief complaint) \_\_\_\_\_

**Medications** (please include prescription & non-prescription medications), **write "No" if none.**

\_\_\_\_\_  
\_\_\_\_\_

**Are you allergic to any medications?** No \_\_\_\_ Yes \_\_\_\_ Please specify \_\_\_\_\_

**Are you allergic to latex?** No \_\_\_\_ Yes \_\_\_\_

**Do you have any of the following?** (Review of systems)- circle any that apply to you

Fevers	Recurrent mouth sores	Stomach (ulcers, reflux, pain)	Bowel problems
Cough	Joint aches/Arthritis	Leg swelling	Kidney problems
Glaucoma	Pacemaker	High Blood Pressure	Herpes Infection
Weakness	HIV/AIDS	History Blood Transfusions	Rheumatic fever
Seizures	Overgrown scars or keloids	Cancer (type) _____	Other _____

**Past Medical History/Family History**

Disease	Yourself	Blood relative	Disease	Yourself	Blood relative
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal moles (dysplastic)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Basal cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Squamous cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>			

**Do you have an artificial heart valve, joint or other prosthesis that requires you to take antibiotics when you have dental work?** Yes \_\_\_\_ No \_\_\_\_

**Past Hospitalization(s)**

Date	Reason
_____	_____
_____	_____
_____	_____

**Do you smoke?** Yes \_\_\_\_ No \_\_\_\_ **Do you drink alcohol?** Yes \_\_\_\_ No \_\_\_\_ How often? \_\_\_\_\_

**For women only:** Are you Pregnant? Yes \_\_\_\_ No \_\_\_\_ Trying to become pregnant? Yes \_\_\_\_ No \_\_\_\_  
Breast feeding? Yes \_\_\_\_ No \_\_\_\_ Taking birth control pills? Yes \_\_\_\_ No \_\_\_\_

We offer a full range of cosmetic procedures. Please indicate whether you are interested in learning more about: Circle those that apply

Botox	Collagen	Laser Hair Removal	Liposuction	Leg Vein Treatment
Restylane	Chemical Peels	Microdermabrasion	Skin care advice	Skin Care Products

(do not write below this line)

Reviewed \_\_\_\_\_ Updated \_\_\_\_\_ Updated \_\_\_\_\_  
Updated \_\_\_\_\_ Updated \_\_\_\_\_ Updated \_\_\_\_\_