PLEASE PRINT

FIRST NAME:_____

LAST NAME:_____ M.I.:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____

CELL PHONE:_____

WORK PHONE:_____

SEX:_____ DOB:_____ AGE:_____

SS#:_____

MARITAL STATUS:_____

EMPLOYER/OCCUPATION:_____

RACE: WHITE ☐ BLACK/AFRICAN AMER. ☐ ASIAN ☐

OTHER ☐ UNKNOWN ☐

LANG: ENG ☐ SPAN ☐ OTHER ☐

ETHNICITY: HISPANIC/LATINO ☐ NON HISPANIC/LATINO ☐

OTHER ☐ UNKNOWN ☐

EMAIL:_____

REFERRING DOCTOR (FULL NAME):_____

REFERRING DOCTOR'S ADDRESS:_____

PHARMACY NAME/NUMBER:_____

_____

PRIMARY INSURANCE COVERAGE INFORMATION (Office use)

INSURANCE CARRIER:_____

POLICY NUMBER:_____

GROUP #:_____ SPECIALIST COPAY:_____

SECONDARY INSURANCE COVERAGE INFORMATION

INSURANCE CARRIER:_____

POLICY NUMBER:_____

GROUP #:_____

GUARANTOR (COMPLETE FOR PATIENT UNDER 18 YRS OF AGE)

FIRST NAME:_____

LAST NAME:_____ M.I.:_____

ADDRESS: SAME AS PATIENTS ☐

_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____

CELL PHONE:_____

WORK PHONE:_____

SEX:_____ DOB:_____

SS#:_____

PRIMARY INSURANCE POLICY HOLDER

PATIENT ☐

OTHER: PLEASE COMPLETE THE FOLLOWING

FIRST NAME:_____

LAST NAME:_____ M.I.:_____

RELATIONSHIP TO PATIENT:_____

PHONE:_____

ADDRESS: SAME AS PATIENTS ☐

_____

CITY:_____ STATE:_____ ZIP:_____

SEX:_____ DOB:_____

SS#:_____

SECONDARY INSURANCE POLICY HOLDER

FIRST NAME:_____

LAST NAME:_____ M.I.:_____

RELATIONSHIP TO PATIENT:_____

SEX:_____ DOB:_____

SS#:_____

DERMATOLOGY PHYSICIANS INC.
203 NORTH LIME STREET
LANCASTER PA 17602
(717) 392-6267

ACCOUNT # _____

DERMATOLOGY PHYSICIANS INC
203 NORTH LIME STREET
LANCASTER PA 17602
(717) 392-6267

Account # _____

Name: _____ Date: _____

Name of Family Physician/Group: _____

Medications you take: name/dose: _____

_____

_____

Allergies: _____

MEDICAL HISTORY:	YES	NO		YES	NO
Diabetes			Pregnant/Attempting to Conceive		
High Blood Pressure			Lung Disease		
Heart Disease			Liver Disease		
Chest Pain			Cataracts (Glaucoma)		
Urinary/Bladder Infection			Shortness of Breath		
Thrombophlebitis (blood clots)			Neurological Disorders		
Artificial Heart Valve			Epilepsy		
Arthritis			Emotional/Psychiatric		
Artificial Joints			Hepatitis		
Frequent Infections (skin/other)			Rheumatic Fever		
Bleeding Disorders			Radiation Therapy		
Ulcers			Seizures		
Keloids			Tuberculosis		
Cold Sores			Thyroid Disease		
Colitis			Other current medical problems:		
Kidney Disease					

Do you have the following: □ Pacemaker □ Defibrillator □ Deep Brain Stimulator □ Cochlear Implant

Prior Surgeries (in last 5 years):

_____

Do you take: □ Aspirin □ Ibuprofen (Advil, Motrin) □ Naproxen (Aleve) □ Dipyridamole

□ Coumadin (Warfarin) □ Plavix (Clopidogrel) □ Pradaxa (Dabigatran) □ Xarelto (Rivaroxaban) □ Vitamin E or Fish Oil

Do you take prophylactic antibiotics for dental surgery? □ Yes □ No

Prior skin cancer? □ Melanoma □ Basal cell carcinoma □ Squamous cell carcinoma □ Unsure of type

Cancer/Date:

_____

FAMILY HISTORY: □ Melanoma (relationship) _____ □ Other Skin Cancer_____

SOCIAL HISTORY: Do you smoke? □ Yes □ No Do you drink alcohol? □ Yes □ No # drinks/week _____

Tanning bed use: □ currently using □ Used in past □ never used

Dermatology Physicians, Inc.
203 North Lime Street
Lancaster PA 17602
(717) 392-6267

I authorize Dermatology Physicians Inc. to disclose any medical information pertaining to my treatment and/or care to the following:

_____	_____
Print Name	Relationship to Patient
_____	_____
Print Name	Relationship to Patient
_____	_____
Print Name	Relationship to Patient

I do not authorize disclosure to anyone other than myself. □

_____
Patient Name (Please Print)

_____ _____
Signature (Persons over 18 years of age) Date

Relationship: Patient □ Parent □ Legal Guardian/POA □ Other □ _____