Horizon Dermatology
& LASER INSTITUTE

E-Mail_____

Patient Information

Name:_____ DOB:___/___/____ Age:_____ Sex: M/F
First Middle Last

Home Address:_____
Street City State Zip

Work Address:_____

Home Phone:_____Work Phone:_____ Cell Phone:_____

SSN:_____-_____-_____ Driver's Lic: _____ Occupation: _____

RESPONSIBLE PARTY INFORMATION(IF DIFFERENT FROM PATIENT)

NAME:_____ SSN:_____

Address:_____ DOB:____/_____/_____

Home Phone_____ Work Phone_____ Cell Phone:_____

INSURANCE INFORMATION(Please present Insurance Card & Driver's Lic. at time of check-in)

Insurance Name: _____

Insurance Address:_____

Name of Insured:_____Insured ID #_____Group #_____

Insured's SSN#_____-_____-_____DOB____/____/_____ Relationship to Insured:_____

IN EMERGENCY, WHOM MAY WE CONTACT?

Name:_____Relationship:_____Phone:_____

Address:_____

Referred By:_____

Preferred Pharmacy:_____Phone:_____

Do we have permission to: Leave a message on your answering machine at home? Yes/No

Leave a message at your place of employment? Yes/No

Discuss your medical condition with family? Yes/No

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance application, and prescriptions. I hereby assign my insurance benefits to be made directly to my physician for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.

PATIENT OR RESPONSIBLE PARTY SIGNATURE_____

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Patient Name:_____**Date**:_____

Are you allergic to any medications? Yes/No If yes, please list below:

_____

List all medication you are currently taking (including prescriptions, over-the-counter meds including asprin, herbals, vitamins):

_____

_____

Do you take any blood thinners like asprin, coumadin, plavix, motrin, Vitamin E? Yes/No

Do you have or have you ever had any diseases or conditions of: (Please circle all that apply)

High Blood Pressure	Diabetes
Heart Attack/Angina	Thyroid Disease
Heart Murmur	Urinary Disease
Pacemaker	Stomach Ulcers
Anxiety	Hepatitis
Mitral Valve Prolapse	Dialysis
AIDS/HIV	Arthritis
Artificial Valves	Artificial Joints
Asthma	Fainting
Shortness of Breath	Seizures
Tuberculosis	Stroke
Blood Clots	Migraines
Sinus Allergies	Depression
	Other:_____

List any major surgeries:_____

(Women) Are you currently pregnant or nursing? Yes/No

Have you ever had skin cancer? Yes/No If yes, explain:_____

Has any blood relative had any skin cancer? Yes/No If yes, explain:_____

Do you have any history of any skin diseases? Yes/No If yes, explain:_____

Do you have any problems with healing? Yes/No If yes, explain:_____

Do you keloid or scar easily? Yes/No If yes, explain_____

SOCIAL HISTORY:

Do you drink alcohol? Yes/No If yes _____ drinks per day/week

Do you use IV drugs Yes/No If yes, what?_____

Do you smoke? Yes/No If yes, how much?_____

Have you had or been exposed to HIV/AIDS Yes/No

What is your current occupation?_____

What are your hobbies?_____

Patient Signature:_____Date:_____