Advanced Dermatology & Skin Surgery, PC
456 Chestnut Street, Suite 201
Lakewood, NJ 08701
(732)905-9200 Fax(732)905-4470

TO HELP US GIVE YOU THE BEST POSSIBLE CARE, PLEASE CAREFULLY COMPLETE ALL QUESTIONS ON THIS FORM. Circle "yes" or "no". If unaware of an answer, leave it blank.

I. Do you take any medicine, drugs, or over-the-counter preparations or remedies?
If yes, please list _____
_____
_____

II. Have you ever had or been treated for any of the following?

1. Excessive sun exposure in childhood or teen years……. yes no
2. Sunburns…….……. yes no
3. Melanoma …….……...yes no
4. Skin cancer (if yes, please specify) …… ..yes no
5. Keloids or excessive scars…….... yes no
6. Allergy to local anesthetics (if yes, please specify which ones) ..... yes no
7. Excessive bleeding when cut……yes no
8. Difficulty with the healing of wounds…….….yes no
9. Conditions requiring prophylactic antibiotics……..yes no
10. Eczema…….….yes no
11. Asthma…….….yes no
12. Hay fever……..yes no
13. Psoriasis……yes no
14. Ulcer or intestinal disease……yes no
15. Liver disease……yes no
16. Lung disease (tuberculosis, other)…...……yes no
17. Heart disease (rheumatic fever, pacemaker, artificial heart valves, etc) yes no
18. High blood pressure…….….yes no
19. Kidney disease…….….yes no
20. Venereal disease…….…….yes no
21. Blood disorder or lymph gland disorder……..…….yes no
22. Eye disease (glaucoma, cataract, other)…….……...yes no
23. Arthritis, joint problem or bone disease……...yes no
24. Cancer (other than skin)……...yes no
25. Neurological disorder……...yes no
26. Emotional or psychiatric problem……yes no
27. Diabetes……yes no

Other conditions (please specify)_____

OVER

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III. Have you previously had a skin problem or been under the care of a dermatologist? (If YES please describe)

_____

_____

IV. Are you ALLERGIC to any medicines, drugs, or over-the-counter preparations or remedies……..yes no
If YES, what are you allergic to_____

V. Prior hospitalizations or surgery…… yes no
If YES, please list and give dates

_____

_____

VI. Have any members of your family had (specify who):

1. Asthma……..…….……..……yes no
2. Hay fever….…….yes no
3. Eczema…….…….yes no
4. Psoriasis……...…….yes no
5. Melanoma…….yes no
6. Skin cancer other than melanoma…….yes no
7. Other skin conditions (specify) ……...…….yes no

VII. Social history

1. Do you smoke? ……yes no
2. Do you drink alcohol? …….yes no
3. Have you been exposed to HIV?.…….yes no
4. Have you been exposed to Hepatitis C or D viruses? …….yes no
5. Are you married, single, divorced, separated, widowed? (circle one)
6. Do you do outdoor work or outdoor hobbies? …….yes no

VIII. For **women** only

1. Have you had frequent vaginal yeast infections: …….yes no
2. Are you pregnant? ……...….……...….yes no
3. Are you currently planning a pregnancy? ...…….yes no
4. Are you nursing? …….yes no
5. Do you have regular menstrual periods? …….yes no

NOTE: THE DERMATOLOGICAL EXAMINATION WHICH YOU ARE ABOUT TO RECEIVE IS NOT A COMPLETE PHYSICAL EXAMINATION IT IS SUGGESTED THAT YOU HAVE A COMPLETE PHYSICAL EXAMINATION PERIODICALLY BY YOUR FAMILY PHYSICIAN OR INTERNIST.

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Patient Name: _____
Patient's Date of Birth: _____
Patient's Social Security Number: _____-_____-_____
Patient's Address: _____
City State Zip
Patient's Phone Number: _____
Patient's Cell Phone Number: _____
Primary Care Physician: _____**Phone #**_____
Occupation/Former Occupation:_____

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits and that a finance charge will accrue on my unpaid balance older than 30 days.

I understand that if I have a biopsy, specimens may be sent to an out of state lab (NY) as the doctor sees fit. **IT IS THE PATIENT'S RESPONSIBILITY TO INFORM THE MEDICAL ASSISTANT IF THEIR INSURANCE REQUIRES THEM TO USE A SPECIFIC LABORATORY. ADVANCED DERMATOLOGY & SKIN SURGERY CANNOT ASSUME RESPONSIBILITY IF THE PATIENT HAS A DEDUCTIBLE OR COINSURANCE FOR LAB SERVICES. IT IS THE PATIENT'S RESPONSIBILITY FOR ALL BILLS THAT MAY BE INCURRED FOR SERVICES RENDERRED**. ***If I require a NJ LAB (Quest, Labcorp), it is MY responsibility to notify the physician or medical assistant.***

I authorize the release of medical information to my primary care or referring physician, to consultants if need and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature _____ Date___/___/____

SIGNATURE OF PARENT OR RESPONSIBLE PARTY (if different than patient)

Name _____
Last First M.I.

The following information is required for Medicare purposes:
Race:_____ Ethnicity:_____ Primary language:_____
Email address:_____

INSURANCE SUBSCRIBER (if different than patient)
Name of Subscriber: _____
Social Security Number _____-_____-_____
Date of Birth: _____