Patient Name:____DOB__________

Reason for Today's visit:____

Preferred Pharmacy:____

Pharmacy name address city

Primary Care Physician:____

Medications taken on a regular basis:____

Allergies to Drugs:____

Have you ever had or have: (Please Circle)

High Blood Pressure: Yes/No
Diabetes: Yes/No
Kidney Disease: Yes/No
Colitis: Yes/No
Cancer: Yes/No Type:________________
Skin Cancer: Yes/No Type:________________
Family History of Skin Cancer: Yes/No Type:_________Who (1st degree relative): ___
Have you received the Flu Vaccine This Season? Yes/No
Have you ever received the Pneumonia Vaccine? Yes/No
What is your current smoking status? Current/Former/Never
Do you consume alcohol? Yes/No
3 or More Drinks per Day Yes/No

In the past year, how many times have you had 4+drinks (5+for men under 65) in one day:__________

Do you have a Health Care Proxy/Living Will? Yes/No
If yes, please list name:_____________________________________

Relation to you:___________________Contact number:________________________

Do you authorize us to leave a voicemail on phone number listed: Yes No
How did you hear about us? ____

I hereby authorize and assign my insurance benefits to be paid directly to DermPhysicians of New England. I authorize release of information to facilitate treatment, payment or health care operations. I give DermPhysicians of New England permission to treat me and take photographs. I have read and understand the Notice of Privacy Rights and Practices and DermPhysicians of New England policies. Co-Payments and/or outstanding balances are due at the time of your appointment. I agree that I will be financially responsible for any treatment I receive, in the event that my insurance company denies payment due to lack of referral or a non-covered service. I will be responsible for a $30. Fee in the event that my check is returned for insufficient funds or my account is turned over to a collection agency. My signature below signifies my understanding and agreement to comply with this policy. All information has been verified and/or corrected on this form.

Signature of Patient
(or responsible party)___________________________________Date:__________________

I authorize the following person to have access to my medical and financial information which can be revoked at any time in writing.

Name____Phone Number:___________________