Provider: _____ Date of Service: _____

Patient Name_____DOB: _____

Reason for Today's Visit: _____

Preferred Pharmacy: _____
Pharmacy name Address City

Primary Care Physician: _____
First Name Last name Town/City

Medications taken on regular basis: _____

Drug Allergies: _____

Have you ever had or have: (Check Mark what applies)?

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Colitis
- ☐ Cancer – Type: _____
- ☐ Skin Cancer-Type: _____
- ☐ Family history of skin cancer-Type: _____Who (1st degree relative only): _____
- ☐ Other chronic illness – Type: _____

Have you ever received?

Pneumonia Vaccine (65yrs+)? Yes ☐ No ☐

Flu Vaccine (this season) Yes ☐ No ☐

Current Smoking Status? Current ☐ Former ☐ Never ☐

Do you Consume Alcohol? Yes ☐ Never ☐

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: _____

Emergency Contact: _____
Name Phone# Relation

Do you authorize the practice to leave a voicemail on phone number listed? Yes ☐ No ☐

Personal Email: _____

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 / Responsible party

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**