PATIENT INFORMATION

Name _____ **Date of Birth** _____ **Sex** _____

Single ____ **Married** ____ **Widowed** ____ **Divorced** ____

Home Ph. ( ) _____ **Work** ( ) _____ **Cell** ( ) _____

E-mail Address: _____

Address _____**City** _____ **State** _____ **Zip** _____

How did you first learn about us _____

Referred By _____

Personal Physician _____ **Phone** ( ) _____

Address _____**City** _____ **State** _____ **Zip** _____

Employed By _____

Occupation _____ **S S #** _____

Spouse/Parent Name _____ **Occupation** _____

Reason for Visit: _____

Significant Medical and Skin Illness - present/past: _____
_____

Operations and Hospitalizations:_____
_____

Previous History of Cosmetic Procedures/Surgeries:_____

Current Medications: _____
_____

ALLERGIES: Medications: _____

Personal &/or Family History of:

Skin Cancer	_____	Diabetes	_____
Eczema	_____	Herpes	_____
Psoriasis	_____	AIDS/Hepatitis	_____
Other Skin Diseases	_____	Blood Clots	_____

I hereby authorize direct payment to The Skin & Laser Surgery Center of New England for dermatology services I receive. I also authorize the release of medical information to my insurance company. I understand that I am financially responsible for services not covered by my insurance policy.

_____ _____

Signature of Patient/Parent **Date**