

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