Seff Dermatology

Date_____

Have you been a patient in this office in the past?_____ If so, how long ago?_____

Patient's Social Security Number: (or last 4 digits)_____

Patient's First Name _____ MI: ____ Last Name _____

Sex Male/Female Date of Birth: _____ If Married, Spouse's Name : _____

Home street address:_____

City: _____State: _____ Zip Code: _____-

Email address: _____

Home phone : _____Cell phone: _____ Work phone: _____

If patient is a minor, Parent's name(s)_____

Patient's Occupation: _____ Employer or School: _____

Primary Physician: _____Address:_____

How were you referred to this office?: _____

Pharmacy name and phone number:_____

Pharmacy location:_____

Allergies to medications: Yes No If yes, please list:_____

_____

A list of current prescription medications and over-the-counter medicines and supplements will be obtained during the visit

PAST MEDICAL HISTORY (please list all relevant medical conditions):_____

_____

_____

PAST SURGICAL HISTORY (please list any relevant surgical history): _____

_____

_____

SKIN DISEASE HISTORY (please circle all that apply)

Acne	Blistering Sunburns	Precancerous Moles
Actinic Keratoses	Eczema	Psoriasis
Basal Cell Skin Cancer	Melanoma	Squamous Cell Skin Cancer

Other _____

Do you wear sunscreen? Yes No If yes, what SPF? _____

Do you have a family history of skin cancer? Yes No If yes, who and which kind? _____

_____

Please answer the following regarding appointments, follow-up, biopsy results, lab results, etc:

May we leave medical information on a voicemail or answering machine? Yes No

May we contact you at your place of employment? Yes No

May we mail personal medical information including recall notices to your home? Yes No

May we discuss medical information with a member of your household? Yes No

If yes, whom: _____ Relationship: _____

Signature Authorization

IN ORDER TO PROTECT YOUR PRIVACY YOUR SIGNATURE AUTHORIZES: MEDICAL TREATMENT, DISCLOSURE OF ANY MEDICAL INFORMATION FOR PROCESSING OF INSURANCE CLAIMS, AND MAILING CORRESPONDENCE SUCH AS APPOINTMENT REMINDERS AND BILLING STATEMENTS TO YOUR HOME ADDRESS. YOUR SIGNATURE ALSO ASSIGNS PAYMENT OF INSURANCE BENEFITS TO DR. DANIEL SEFF, ALLOWS PROCESSING OF YOUR OFFICE NOTE DICTATION BY A THIRD PARTY, AND ALLOWS FOR INFORMATION TO BE SENT TO AN OUTSIDE LAB IF NECESSARY.

IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE MOST UP TO DATE AND ACCURATE INSURANCE INFORMATION. YOUR SIGNATURE ALSO INDICATES YOU ARE AWARE THAT YOU ARE RESPONSIBLE FOR ANY INSURANCE COPAYMENTS AND/OR DEDUCTIBLES AT THE CONCLUSION OF THE VISIT.

Signature Of Patient:_____ Date:_____

(Parent or Guardian must sign if patient is under the age of 18)