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): _______________________________

____

____

If 19 years old or younger, please provide Height: _________ and Weight: _________

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)