SOUTH NASSAU DERMATOLOGY, P.C.

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WWW.SNDERM.COM.

Name ______________________ **Date** ______________

Address ______________________ **Phone** ______________ **S/S#** __________

Cell Phone ______________________ **Work Phone** ______________

DOB ______________

ANNUAL MEDICAL QUESTIONNAIRE

Please Always Remember To tell Us Of New Developments In Your Medical Background.

Please circle the appropriate answer:

Have you been treated for, or do you have problems with any of the following body systems?

Social History

- neurologic, immunologic or hematologic .... yes no
- eyes, ears, nose & throat .... yes no
- GI: duodenal, peptic ulcers, colitis, or intestinal disease .... yes no
- tuberculosis or lung disease .... yes no
- heart disease or pacemaker .... yes no
- high blood pressure .... yes no
- kidney disease .... yes no
- liver or gall bladder disease .... yes no
- emotional disorders or psychiatric problems .... yes no
- urinary or bladder problems or infections .... yes no
- diabetes, or thyroid or other hormonal problem .... yes no
- venereal diseases .... yes no
- have you ever had cancer .... yes no

Have you ever had radiation treatments, or Grenz ray treatments, x-ray treatments? yes no

Please list areas treated and year of treatment. ______________________

Do you use sun screen? __________ always __________ sometimes __________ never
Do you smoke? __________ Yes __________ No
Do you drink? - How much ? ______________
What soap do you use? ______________
What moisturizer do you use? ______________

Have you had a recent operation or accident? ______________ yes ___ no ___ what? ______

Have you or any of your blood relatives had problems with any of the following:
(please list relationship to person with the problem.) ______________________

			Patient	Family Member
Asthma	yes	no	______________	______________
Hay Fever	yes	no	______________	______________
Hives	yes	no	______________	______________

(Over)

			Patient	Family Member
Eczema	yes	no	______	______
Diabetes	yes	no	______	______
Psoriasis	yes	no	______	______
Skin Cancer	yes	no	______	______

Please tell us if you have any new conditions while you are under our care. If you are pregnant please check with us regarding your treatment.

If you do not desire a complete skin examination please initial here: ____________________

Have you ever had . . . .

difficulty with the healing of wounds	yes	no
excessive bleeding when cut	yes	no
overgrown scars or keloids	yes	no
allergic reactions to local anesthetics	yes	no

Are you allergic to any medications or over the counter remedies? yes no
(if yes, please list.)

Are you now taking any medicines or over the counter remedies? yes no
(if yes, please list.)

Are you undergoing treatment for any medical condition now. yes no
(if yes, please list.)

Have you had a previous skin disease or been treated by a Dermatologist? yes no
(if yes, describe.)

Do you have a heart valve problem or an artifical joint that requires premedication. yes no
(if yes, please list.)

Prior hospitalization and surgery. Please give approximate date.______________

For women only:

Have you had vaginal yeast infections? ____________

Are you pregnant? ______________

Are you planning a pregnancy ________________

(Please inform the doctor if you do plan on becoming / or do become pregnant during your treatment period.)

When was your last period _________________

GUARANTEE OF PAYMENT I/We do hereby and agree to pay South Nassau Dermatology, P.C. the full and entire amount of any and all bills rendered for above named patient for services rendered.

If I am a managed care or HMO patient I assume responsibility for any services that are not a part of my referral, and will pay for those services at the time they are provided.

________________ ________________________

Date Signature

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PATIENT INFORMATION SHEET

PATIENT LAST NAME: ______________________________

PATIENT FIRST NAME: ______________________________ MIDDLE INITAL: __________

SOCIAL SECURITY NUMBER: ______________________________

STREET ADDRESS: ______________________________

CITY, STATE, ZIP: ______________________________

DATE OF BIRTH: ____________________ SEX: MALE __________ FEMALE __________

MARITAL STATUS: MARRIED ________ SINGLE ________ DIVORCED ________ WIDOWED ________

HOME PHONE: ____________________ WORK PHONE ____________________

CELL PHONE: ____________________ EMERGENCY CONTACT: ____________________

PHARMACY # ____________________

PRIMARY CARE DOCTOR: ______________________________

ADDRESS: ____________________ PHONE NUMBER: ____________________

PRIMARY INSURANCE: ______________________________

POLICY HOLDER NAME: ______________________________

POLICY HOLDER S.S.#.: ____________________ POLICY HOLDER DATE OF BIRTH: __________

INSURANCE ID NUMBER: ______________________________

RELATIONSHIP TO POLICY HOLDER: SELF ________ SPOUSE ________ CHILD ________ OTHER ________

CO-PAY AMOUNT: ____________________ DO YOU NEED A REFERRAL? YES ________ NO ________

SECONDARY INSURANCE: ______________________________

POLICY HOLDER NAME : ______________________________

POLICY HOLDER S.S.#.: ____________________ POLICY HOLDER DATE OF BIRTH: __________

INSURANCE ID NUMBER: ______________________________

RELATIONSHIP TO POLICY HOLDER: SELF ________ SPOUSE ________ CHILD ________ OTHER ________

CO-PAY AMOUNT: ____________________ DO YOU NEED A REFERRAL? YES ________ NO ________

EMPLOYMENT: **EMPLOYED:** YES ______ NO ______ **STUDENT:** PART TIME ________ FULL TIME ______

RETIRED: YES ________ NO ________

SIGNATURE OF RESPONSIBLE PARTY: ______________________________ **DATE:** ______________

Form 1105