DERMATOLOGY MEDICAL GROUP OF SAN FRANCISCO

NEW PATIENT REGISTRATION & MEDICAL HISTORY

DATE:		
PATIENT INFORMATION		
Patient's last name	First	Middle
Home Address:	City:	State/ Zip Code:

Preferred Contact Number: *Please indicate which phone number we are authorized to use for confidential information. i.e. lab results, appointment reminders*

☐ Home: ☐ Cell: May we leave a message? ☐ Yes ☐ No

Email:

Do you authorize us to send information to this email address? ☐ Yes ☐ No

Social Security no:	Birth date:	Age:	Sex:	Marital Status:
	/ /		☐M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation:	Employer:	Employer phone no.:

Spouse/ Partner Last Name, First Name:

EMERGENCY CONTACT

Name:	Relationship to patient:	Contact Number:

Primary Care Physician's Name:	Phone Number:

PCP Address/Suite:	City:	State/Zip:

Referred by: ☐ Physician ☐Patient ☐ Website ☐Other

Other: (Name) _____ (Number)_____

Reasons for today's visit:

How long have you had it?

Have you been treated for this condition?

INSURANCE INFORMATION	
PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured:	Name of Insured:
Relationship to Patient:	Relationship to Patient:
Insured's Birth date:	Insured's Birth date:
Social Security #: _____-_____-_____	Social Security #: _____-_____-_____
Employer:	Employer:
Insurance Co.:	Insurance Co.:
Employee I.D/ Cert. #:	Employee I.D/ Cert. #:
Group #:	Group #:

FINANCIAL POLICY

I, the undersigned, understand that I am receiving services from an *out-of-network provider*. This means that DMGSF does not participate in my insurance plan.

Since DMGSF does not participate with my insurance plan, *full payment is due at the time services are rendered.*

As a courtesy, Dermatology Medical Group of San Francisco will submit claims to my insurance on my behalf and I understand that I am financially responsible for all charges incurred with the Dermatology Medical Group of San Francisco, Inc.

Name: (Please Print):_____ Signature: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

***Please see clipboard**

I hereby acknowledge receipt of Dermatology Medical Group of San Francisco's Notice of Privacy Practices.

Name: (Please Print):_____ Signature:_____

Or

I am a parent or legal guardian of _____ (Patient Name). I hereby acknowledge receipt of Dermatology Medical Group of San Francisco's Notice of Privacy Practices with respect to the patient.

Name: (Please Print) _____

Relationship to Patient: _____

Signature: _____

Name: _____ **Date:**_____
Date of Birth:_____

REVIEW OF SYSTEMS: (PLEASE CHECK ALL THAT APPLY)

PROBLEMS WITH BLEEDING:	IMMUNOSUPPRESSION ALLERGIC:	ALLERGY TO TOPICAL ANTIBIOTICS:
PROBLEMS WITH HEALING:	DEFIBRILLATOR?:	PREMEDICATION PRIOR TO PROCEDURE:
PROBLEMS WITH SCARRING:	ALLERGY TO ADHESIVE:	BLOOD THINNERS:
RAPID HEARTBEAT WITH EPINEPHRINE:	ALLERGY TO LIDOCAINE:	PACEMAKER:

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY

ANXIETY	CORONARY ARTERY DISEASE	HIV/AIDS
ARTHRITIS	CHEST PAIN	HYPERCHOLESTEROLEMIA
ASTHMA	DEPRESSION	LEUKEMIA
ATRIAL FIBRILLATION	DIABETES	LYMPHOMA
BLOODY STOOL/URINE	END STAGE RENAL DISEASE	SEIZURES
BLURRY VISION	GERD	STROKE
BONE MARROW TRANSPLANTATION	HEARING LOSS	THYROID PROBLEMS
CANCER	HEPATITIS	UNINTENTIONAL WEIGHT LOSS
COPD	HYPERTENSION	WHEEZING

OTHER: _____

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

BASAL CELL CANCER SURGERY	KIDNEY BIOPSY
BIOLOGICAL VALVE REPLACEMENT	KIDNEY REMOVAL: RIGHT OR LEFT
BLADDER REMOVED	KIDNEY STONE REMOVAL
BREAST BIOPSY	KIDNEY TRANSPLANT
BREAST REDUCTION OR IMPLANTS	LUPECTOMY: RIGHT, LEFT OR BILATERAL
COLECTOMY: COLON CANCER RESECTION	MASTECTOMY: RIGHT, LEFT OR BILATERAL
COLECTOMY: DIVERTICULITIS APPENDIX REMOVED	MECHANICAL VALCE REPLACEMENT
COLECTOMY: IBD	MELANOMA SURGERY
CORONARY ARTERY BYPASS	OVARIES REMOVED: ENDOMETRIOSIS
GALLBADDER REMOVED	OVARIES REMOVED: CYST
HEART TRANSPLANT	OVARIES REMOVED: OVARIAN CANCER
HYSTERECTOMY: FIBROIDS	PROSTATE BIOSPY
HYSTERECTOMY: UTERINE CANCER	SKIN BIOPSY

OTHER:_____

SKIN HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ACNE	ECZEMA	PRECANCEROUS MOLES
ACTINIC KERATOSES	FLAKY OR ITCHY SCALP	PSORIASIS
BASAL CELL SKIN CANCER	HAY FEVER/ALLERGIES	ROSACEA
DRY SKIN	MELANOMA	SQUAMOUS CELL SKIN CANCER

OTHER:_____

DO YOU WEAR SUNSCREEN? YES_____ NO_____ IF YES, WHAT SPF?_____

DO YOU TAN IN A TANNING SALON? YES_____ NO_____

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? YES_____ NO_____

IF YES, WHICH RELATIVE(S)? _____

CURRENT MEDICATIONS:
(PLEASE INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDICATIONS)

DRUG NAME AND DOSAGE	
1.	**4.**
2.	**5.**
3.	**6.**

ALLERGIES (MEDICATION AND FOOD/CONTACT)

NAME OF MEDICATION AND TYPE OF REACTION
1.
2.
3.
4.

SMOKING STATUS (CHECK ONE) **NEVER BEEN A SMOKER** **FORMER SMOKER**
CURRENT SOMETIME SMOKER **CURRENT EVERYDAY SMOKER**
DECLINED TO SPECIFY

ALCOHOL STATUS (CHECK ONE) **NONE** **LESS THAN 1 DRINK PER DAY**
3 OR MORE DRINKS PER DAY **1-2 DRINKS PER DAY**
DECLINED TO SPECIFY

RACE (CHECK ONE) **AMERICAN INDIAN/ALASKAN NATIVE** **ASIAN**
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDS **WHITE**
BLACK/AFRICAN AMERICAN **HISPANIC/LATINO**
DECLINED TO SPECIFY

PREFFERED LANGUAGE: **ENGLISH** **SPANISH** **OTHER _____**

PREFFERED PHARMACY (PLEASE INCLUDE NAME, PHONE NUMBER AND ADDRESS OF PHARMACY)

_____

_____