NEW PATIENT REGISTRATION & MEDICAL HISTORY

DATE:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Preferred Pronouns:
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, etc.

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 Number:	Birth Date:	Age:	Birth Sex:	Gender Identity	Marital Status
	/ /		M □ F □ Other __________	M □ F □ Other __________	Single □ Married □ Divorced □ Widowed □

Occupation:	Employer:	Employer Phone Number:

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 Code:**

Referred by: **Physician** **Patient** **Website**

Name:

Reasons for today's visit:

How long have you had it?

Have you been treated for this condition?

PATIENT 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:
Employer:	Employer:
Insurance Co:	Insurance Co:
Employee I.D./Cert. #:	Employee I.D./Cert. #:
Group #:	Group #:

FINANCIAL POLICY FOR OUT-OF-NETWORK

I, the undersigned, understand that I am receiving services from an out-of-network provider. This means 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 company 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:(PleasePrint):___________________________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 ___________________ (patients 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)

ANXIETY DISORDER ARTHRITIS ASTHMA ATRIAL FIBRILLATION BENIGN PROSTATIC HYPERPLASIA CEREBROVASCULAR ACCIDENT CHRONIC OBSTRUCTIVE LUNG DISEASE CORONARY ARTERIOSCLEROSIS DEPRESSIVE DISORDER DIABETES MELLITUS DISEASE CAUSED BY 2019-nCoV ELEVATED BLOOD PRESSURE END STAGE RENAL DISEASE EPILEPSY GASTROESOPHAGEAL REFLUX DISEASE H/O: HYPERTENSION HEARING LOSS	HUMAN IMMUNODEFICIENCY VIRUS INFECTION HYPERCHOLESTEROLEMIA HYPERTHYROIDISM HYPOTHYROIDISM INFLAMMATORY DISEASE OF LIVER LEUKEMIA MALIGNANT LYMPHOMA MALIGNANT TUMOR OF BREAST MALIGNANT TUMOR OF COLON MALIGNANT TUMOR OF LUNG MALIGNANT TUMOR OF PROSTATE RADIATION THERAPY TREATMENT MANAGEMENT TRANSPLANTATION OF BONE MARROW OTHER: ____

PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

ABDOMINOPERINEAL RESECTION BILATERAL REPLACEMENT OF KNEE JOINTS BIOPSY OF BREAST BIOPSY OF PROSTATE CORONARY ARTERY BYPASS GRAFT ENTIRE TRANSPLANTED KIDNEY EXCISION OF BASAL CELL CARINOMA EXCISION OF MELANOMA EXCISION OF SQUAMOUS CELL CARCINOMA H/O: COLOSTOMY H/O: TUBAL LIGATION HISTORY OF APPENDECTOMY HISTORYT OF BILATERAL MASTECTOMY HISTORY OF CHOLECYSTECTOMY HISTORY OF COLECTOMY HISTORY OF LIVER EXCISION HISTORY OF PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY HISTORY OF TISSUE GRAFT HEART VALVE REPLACEMENT HISTORY OF TOTAL CYSTECTOMY HISTORY OF TRANSURETHRAL PROSTATECTOMY HYSTERECTOMY KIDNEY BIOPSY LOW ANTERIOR RESECTION OF RECTUM	LUMPECTOMY OF LEFT BREAST LUMPECTOMY OF RIGHT BREAST MASECTOMY OF LEFT BREAST MASECTOMY OF RIGHT BREAST MECHANICAL HEART VALVE REPLACEMENT OOPHORECTOMY PANCREATECTOMY PERCUTANEOUS EXTRACTION OF KIDNEY STONE WITH FRAGMENTATION PROCEDURE PORTOSYSTEMIC SHUNT OPERATION PROSTATECTOMY PROSTHETIC ARTHOPLASTY OF BILATERAL HIPS SPLENECTOMY SURGICAL BIOPSY OF SKIN TOTAL NEPHRECTOMY TOTAL ORCHIDECTOMY TOTAL REPLACEMENT OF LEFT HIP JOINT TOTAL REPLACEMENT OF LEFT KNEE JOINT TOTAL REPLACEMENT OF RIGHT HIP JOINT TOTAL REPLACEMENT OF RIGHT KNEE JOINT TRANSPLANTATION OF HEART TRANSPLANTATION OF LIVER OTHER: ____

SKIN HISTORY: (PLEASE CHECK ALL THAT APPLY)

ACNE ACTINIC KERATOSIS ASTEATOSIS CUTIS BASAL CELL CARCINOMA OF SKIN CONTACT DERMATITIS DUE TO POISON IVY DYSPLASTIC NEVUS OF SKIN ECZEMA	H/O: ASTHMA H/O: HAY FEVER MALIGNANT MELANOMA PRURITUS OF SCALP PSORIASIS SQUAMOUS CELL CARCINOMA SUNBURN OF SECOND DEGREE 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.	**2.**
3.	**4.**
5.	**6.**

ALLERGIES (MEDICATION AND FOOD/CONTACT)

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

TOBACCO SMOKING STATUS (CHECK ONE)	**NEVER BEEN A SMOKER** **CURRENT SOMETIME SMOKER** **DECLINED TO SPECIFY**	**FORMER SMOKER** **CURRENT EVERYDAY SMOKER**
ALCOHOL STATUS (CHECK ONE)	**NONE** **3 OR MORE DRINKS PER DAY** **DECLINED TO SPECIFY**	**LESS THAN 1 DRINK PER DAY** **1-2 DRINKS PER DAY**
RACE (CHECK ONE)	**AMERICAN INDIAN/ALASKAN NATIVE** **NATIVE HAWAIIN/OTHER PACIFIC ISLANDS** **BLACK/AFRICAN AMERICAN** **DECLINED TO SPECIFY**	**ASIAN** **WHITE** **HISPANIC/LATINO**

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