

THE DERMATOLOGY INSTITUTE OF BOSTON

Name: _____ Address: _____

Phone: _____ Email: _____ Date of birth: _____ Male Female

If we need to call you, may we leave detailed personal medical information (such as test results) on your voicemail? Yes No

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Primary Care Physician Name and Address: _____

Pharmacy Name and Address: _____

INSURANCE	
***ARE YOU COVERED UNDER A PARENT'S OR SPOUSE'S INSURANCE PLAN? IF SO, THAT PERSON IS THE "SUBSCRIBER".	
SUBSCRIBER NAME: _____	YOUR RELATIONSHIP TO THE SUBSCRIBER: _____
SUBSCRIBER ADDRESS: _____	SUBSCRIBER DATE OF BIRTH: _____
INSURANCE: _____	STATE _____
POLICY/ID NUMBER: _____	GROUP NUMBER: _____
PLAN TYPE: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> OTHER _____	

How did you hear about us? Online search Facebook Twitter Instagram Newspaper Word-of-mouth Yelp.com Work in this building
 Insurance website Referred by another physician named: _____ Other: _____

Reasons for today's visit: _____

Do you have questions about cosmetic treatments? No Yes If so, what would you like to discuss? _____
Please note that a cosmetic consultation fee of \$150 may apply. Time permitting, a consultation can be done today.

Have you ever been diagnosed with any medical conditions? If yes, please list and/or circle below.

Acne	Cold Sores	Heart Murmur	Implanted Metal
Anxiety	Depression	Hepatitis B or C	Pacemaker
Artificial Joints	Diabetes	High Blood Pressure	Seizures
Bleeding Disorders	Eczema	HIV/AIDS	Skin cancer (list type):

What past illnesses or operations have you had?

Has anyone in your family had a skin cancer? Who and what type of skin cancer? _____

What prescription medications, over the counter supplements, and vitamins do you currently take?

Medication allergies: _____

Have you ever taken isotretinoin (aka Accutane)? Yes No When? _____

Do you use Retin-A, Renova, Adapalene, Differin, Tazarotene, Tazorac, Tri Luma or other retinol products? Yes No

Do you have a fever today? Yes No

Do you have nausea today? Yes No

Do you have excessive bleeding problems? Yes No

Do you develop keloid scars? Yes No

When were you last in the sun? _____

Are you tan now? Yes No

Do you use tanning beds? Yes No

Smoking status: Current smoker Former smoker Never smoker

For female patients: Are you pregnant or trying to get pregnant? Yes No

Breastfeeding? Yes No

Patient signature: _____

Date: _____

Provider signature: _____

Date: _____