



# Boston Dermatology and Laser Center

## PATIENT REGISTRATION

LAST NAME				FIRST NAME & INITIAL			
ADDRESS							
CITY			STATE			ZIP	
CELL PHONE				HOME PHONE			
DATE OF BIRTH			SEX		WORK PHONE		
EMAIL ADDRESS					MARITAL STATUS (M/S)		
PATIENT'S S.S. NUMBER				MGH NUMBER			

### PRIMARY CARE PHYSICIAN'S & PHARMACY INFORMATION

PCP'S NAME						
PCP'S PHONE NUMBER						
PREFERRED PHARMACY (name, street, city)						

### EMPLOYER'S INFORMATION

PATIENT'S EMPLOYER							
EMPLOYER'S ADDRESS							
CITY			STATE			ZIP	
EMPLOYER'S PHONE				POSITION			

### INSURANCE INFORMATION ( IF WE HAVE NOT SCANNED YOUR CARD )

INSURANCE #1				ID NUMBER		
POLICY HOLDER'S LAST NAME				GROUP NUMBER		
POLICY HOLDER'S FIRST NAME				RELATIONSHIP		
INSURANCE #2				ID NUMBER		
POLICY HOLDER'S LAST NAME				GROUP NUMBER		
POLICY HOLDER'S FIRST NAME				RELATIONSHIP		

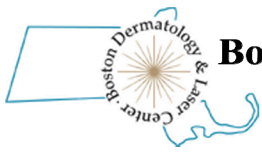
SPOUSE'S NAME						
NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU						

AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the Physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.

SIGNATURE (PATIENT OR PARENT IF MINOR): \_\_\_\_\_

DATE: \_\_\_\_\_



### Confidential Personal Medical History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Other skin issues you wish to discuss: \_\_\_\_\_

(Please circle the items that apply to you and provide details if applicable)

Skin Disease History: Personal history of skin disease..... YES / NO \_\_\_\_\_

Family history of skin disease..... YES / NO \_\_\_\_\_

Personal history of skin cancer ..... YES / NO \_\_\_\_\_

Family history of skin cancer ..... YES / NO \_\_\_\_\_

Medical History: Artificial joint..... YES / NO \_\_\_\_\_

Bleeding disorder/Anemia..... YES / NO \_\_\_\_\_

Mitral valve prolapse/Valve disease..... YES / NO \_\_\_\_\_

Pacemaker..... YES / NO \_\_\_\_\_

Heart disease/Arrhythmia..... YES / NO \_\_\_\_\_

High blood pressure/High cholesterol..... YES / NO \_\_\_\_\_

Arthritis/Orthopedic..... YES / NO \_\_\_\_\_

Infectious disease..... YES / NO \_\_\_\_\_

History of cancer (type)..... YES / NO \_\_\_\_\_

Stomach/Intestinal disorders/GERD..... YES / NO \_\_\_\_\_

Hepatitis/Liver disease..... YES / NO \_\_\_\_\_

Lung disease/Emphysema..... YES / NO \_\_\_\_\_

Kidney/Bladder disease..... YES / NO \_\_\_\_\_

Thyroid/Diabetes/Endocrine disorders..... YES / NO \_\_\_\_\_

Neurological/Seizures/Stroke..... YES / NO \_\_\_\_\_

Mood/Psychiatric disorder..... YES / NO \_\_\_\_\_

Smoking/Alcohol intake..... YES / NO \_\_\_\_\_

Hearing/Visual impairment..... YES / NO \_\_\_\_\_

Allergies: Allergy to medications/anesthetics..... YES / NO \_\_\_\_\_

Allergy to foods/poison ivy/oak/sumac..... YES / NO \_\_\_\_\_

Surgical History: YES / NO \_\_\_\_\_

Medications: PLEASE LIST ALL MEDICATIONS: \_\_\_\_\_