# THE DERMATOLOGY INSTITUTE OF BOSTON

Legal Name:_____ Preferred Name: _____ Preferred Pronouns:_____

Mailing Address: _____ Phone:_____

Email:_____Date of birth:_____Gender (for Insurance Purposes):_____

Self Identify :_____

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

Occupation:_____ Employer/institution: _____

Emergency Contact Name: _____ Phone:_____ Relationship: _____

Primary Care Physician Name and Address: _____

In the event of a prescription, provide us with a 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:** ☐ **PPO** ☐ **HMO** ☐**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:_____

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**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, Tretinoin, 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

Are you tan now? Yes No

Do you use tanning beds? Yes No

Have you ever fainted with medical procedures or blood draws? 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:**_____