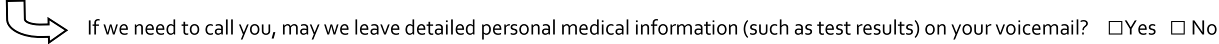
THE DERMATOLOGY INSTITUTE OF BOSTON

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:____________________

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 $175 may apply.*** Time permitting, a consultation can be done today.

Please list all previous cosmetic procedures/surgeries you have had: ____

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 (including contraceptive), 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:**____________