



GENERAL INFORMATION

Patient Name _____ Social Security Number _____
 First Middle Last

Date of Birth _____ / _____ / _____ Age _____ Sex _____ Height _____ Weight _____
 Month Day Year

Address _____
 Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Responsible Person (if Applicable)

Name _____ Relationship to patient _____
 First Middle Last

Date of Birth _____ / _____ / _____ Social Security Number _____
 Month Day Year

Home Phone _____ Work Phone _____ Cell Phone _____

PHARMACY/REFERRAL INFORMATION

Name of Pharmacy _____ City _____

Primary Care Physician _____

How were you referred to our office? (Patient - Doctor) _____

INSURANCE INFORMATION

Do you have health insurance? Yes _____ No _____

Guarantor is the person whose NAME is on the insurance card

Primary Insurance Carrier _____	Secondary Insurance Carrier _____
Name of Guarantor _____	Name of Guarantor _____
Relationship to Patient _____	Relationship to Patient _____
Guarantor Social Security Number _____	Guarantor Social Security Number _____
Guarantor Date of Birth _____	Guarantor Date of Birth _____

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE

I have received a copy of Maryland Dermatology's Notice of Privacy Practices.

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED.

I authorize the doctor and other health-care professionals (clinical staff) to perform diagnostic procedures and treatment as may be necessary for proper medical care. I authorize Maryland Dermatology Associates to release any medical information including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such care to third party payors, and other entities and/or health practitioners. I authorize and assign directly to Maryland Dermatology Associates all medical benefits, if any, otherwise payable to me for services rendered. In the event I have a skin biopsy, I consent to having my biopsy sent to the pathologist my doctor determines is most appropriate for arriving at an accurate diagnosis of my condition. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is turned over to collection agency, I will be responsible for up to a 40% surcharge in addition to my balance.

Patient or Responsible Party Signature

Date

MEDICAL HISTORY

NAME _____ **DATE** _____

What is the primary reason for your visit today? _____
 Have you ever had skin cancer before? If yes, what type? _____
 Female Patients – Are you currently pregnant? Yes No

DRUG ALLERGIES

Name of Drug Type of reaction (rash, hives, nausea, etc.)
 1. _____
 2. _____
 3. _____
 4. _____

CURRENT MEDICAL PROBLEMS

(high blood pressure, diabetes, etc.)
 1. _____
 2. _____
 3. _____
 4. _____

CURRENT MEDICATIONS

Medication Name
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____

PLEASE LIST ANY PAST SURGICAL PROCEDURES

Surgery/Hospital/Location	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

FAMILY HISTORY

Is there a family history of skin cancer? If so, what type? Yes No Type _____
 Is there a family history of any skin disorder? If so, what kind. Yes No Type _____
 Is there any other important family medical history? Yes No List _____
 Do you need to take antibiotics prior to having your teeth cleaned? Yes No
 Do you need help with walking? Yes No
 Do you smoke? Yes No # packs per day _____ How many years have you smoked _____
 Do you drink alcohol? Yes No If yes, how much & how often _____

REVIEW OF SYSTEMS – PLEASE CIRCLE THE PROBLEMS YOU HAVE HAD IN THE LAST FEW WEEKS OR CURRENTLY HAVE

Angina	Double Vision	Indigestion/Reflux	Painful Urination
Arthritis	Difficulty Hearing	Incontinence	Painful Bowel Movements
Abnormal Wound Healing	Depression	Inability to Urinate	Paralysis
Bloody Bowel Movements	Diarrhea	Joint Pains	Prolonged Bleeding
Chills	Difficulty Sleeping	Joint Swelling	Skin Growths
Changes in vision	Ear Pain	Loss of Consciousness	Shortness of Breath
Chronic Rashes	Fevers	Muscle Pains	Seizures
Chest Pains	Fainting	Night Sweats	Ulcers
Cough	Headache	Numbness	Vomiting
Dizziness or Fainting	Heart Palpitations	Nausea	Weight Loss

PAST MEDICAL HISTORY – PLEASE CIRCLE THE PROBLEMS YOU HAVE HAD

Arthritis	Gastric Ulcer	Hearing Impairment	Psychiatric Condition
Anemia	Gonorrhea	Kidney Problems	Rheumatic Fever
Artificial Heart Valve	Gastrointestinal Disorder	Keloids	Sexual/Menstrual Dysfunction
Artificial Joints	HIV/AIDS	Lupus	Syphilis
Asthma	High Blood Pressure	Lyme Disease	Scarlet Fever
Bleeding Disorder	Heart Disease	Mitral Valve Prolapse	Seizures
Diabetes	Heart Attack	Nerve Damage	Stroke
Emphysema	Heart Failure	Osteoporosis	Thyroid Abnormality
Allergies (seasonal)	Heart Surgery	Pacemaker	Tuberculosis
Glaucoma	Hepatitis	Pneumonia	Visual Impairment
Gallbladder Disease	Heart Murmur	Prostate Problems	Vascular Disease

Do you have any disease, condition or problem not listed? If so, please describe below.

 Doctors Signature

 Date

Juris P. Germanas, M.D. Ph.D.

REVIEW OF SYSTEMS

Patient Name: _____

Female patients only

- Currently pregnant Yes No
Currently breastfeeding Yes No

General

- Allergies to medication Yes No
Problems with Anesthesia Yes No

Constitutional

- Recent fever or chill Yes No
Recent weight loss or gain Yes No

Eyes

- Vision problem Yes No
Eye pain/discomfort Yes No

Neurological

- Frequent or sever headache Yes No
Numb / tingling hands or feet Yes No

Endocrine

- Diabetes Yes No
Always tired /sluggish Yes No

Gastrointestinal: recent or frequent

- Abdominal pain Yes No
Nausea / vomiting Yes No
Indigestion / heartburn Yes No

Have you or a family member ever had the following?

- Melanoma Yes No
Other skin cancer Yes No
Psoriasis Yes No
Eczema /dermatitis Yes No
Moderate or severe acne Yes No

Check the box if the answer is yes

- Smoke? Live alone?
 Drink alcohol more than six (6) drinks per week? Wear sunscreen regularly?
 Currently work ? Occupation: _____ Tan regularly (booth or outdoors)?

Cardiovascular

- Yes No
Pacemaker Yes No
Chest pain Yes No
High blood pressure Yes No
High valve problem Yes No

Musculoskeletal

- Joint replacement Yes No
Joint pain /arthritis Yes No

Ear / Nose / Throat : recent or frequent

- Ear infection Yes No
Sore throat Yes No
Sinus problems Yes No

Respiratory /Allergies

- Wheezing /Asthma Yes No
Frequent cough Yes No
Hay fever Yes No

Hermatologic /Lymphatic

- Bleeding problems Yes No
Blood clot or stroke Yes No

Psychologic

- Anxiety disorder Yes No
Mood swings Yes No
Depression Yes No

Why we ask: In dermatology, many conditions may be related to work exposures such as chemicals or intense sun. Also, recuperation from some medical or cosmetic procedures may interfere with work related tasks or public appearances. In addition, patients who live alone may need to have skin exams more frequently if we are following lesions on the back, or may need assistance with dressing changes after a procedure.