PLEASE TELL US ABOUT YOURSELF

Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | **Preferred Language**

Home Address | **Apt #** | **City** | State | Zip Code

Home Phone | **Work Phone** | **Cell Phone**

Please circle where we can leave a message if necessary.

Email Address

PHYSICIAN REFERRAL INFORMATION

Referring Physician/PCP | **Phone #**

Address | **City** | **State** | **Zip Code**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone**

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone**
☐ Cell ☐ Pager ☐ Fax

115 ½ Remsen St Brooklyn, NY 11201

Insurance Information (if used)

Please PRINT

PATIENT INFORMATION

Insurance Company | **Policy Number** | **Group** | **Co-Pay Amount:**

Authorization Number (if required) | **HMO/PPO (circle)** | **Name/DOB of person who 'owns' the policy**

Secondary Insurance | **Policy Number** | **Group**

Pharmacy Information

Address | **City** | **State** | **Zip Code** | **Phone Number**

Medicare Patients

I hereby authorize payment of medical benefits to Heights Dermatology and Laser Group MD PC.

Signature:_____ **Date:**_____

ALL PATIENTS

I hereby give permission to bill insurance company. I realize I am financially responsible for any unpaid balances, deductibles, co-pays, and/or co-insurance. I understand my insurance company will not pay for cosmetic procedures; therefore I am responsible for payment in full.

Signature:_____ **Date:**_____

HEIGHTS DERMATOLOGY AND LASER

Would you like information on any of the following?

Hair Transplantation

Cool Sculpting for Fat Removal

Laser for Hair

Fillers and Botox

PRP for Hair Loss

Laser for Wrinkles

Removal Laser for Redness

Other:_____

Reason for your Visit

_____

_____

Medications: (Please enter all current medications)

_____

_____

Allergies: (Please enter all allergies)

_____

_____

Past Medical History: (please check all that apply)

- ☐ **Anxiety**
- ☐ **Arthritis**
- ☐ **Atrial Fibrillation**
- ☐ **Asthma**
- ☐ **Bone Marrow**
- ☐ **Bleeding Disorder**
- ☐ **Breast Cancer**
- ☐ **Colon Cancer**
- ☐ **COPD**
- ☐ **Coronary Artery Disease**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **End Stage Renal Disease**
- ☐ **GERD**
- ☐ **Hearing Loss**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **HIV/AIDS**
- ☐ **High Cholesterol**
- ☐ **Leukemia**
- ☐ **Lung Cancer**
- ☐ **Lymphoma**
- ☐ **Prostate Cancer**
- ☐ **Radiation Treatment**
- ☐ **Seizures**
- ☐ **Stroke**
- ☐ **Thyroid Problems**
- ☐ **Transplantation**
- ☐ **Do you need prophylaxis?**
- ☐ **NONE**

Other: _____

Past Surgical History: (please check all that apply)

- ☐ **Appendix Removed**
- ☐ **Bladder Removed**
- ☐ **Mastectomy (Right, Left, Bilateral)**
- ☐ **Lumpectomy (Right, Left, Bilateral)**
- ☐ **Breast Biopsy (Right, Left, Bilateral)**
- ☐ **Breast Reduction**
- ☐ **Colectomy: Colon Cancer Resection)**
- ☐ **Colectomy: Diverticulitis**
- ☐ **Colectomy: IBD**
- ☐ **Coronary Artery Bypass**
- ☐ **Gallbladder Removed**
- ☐ **Biological Valve Replacement**
- ☐ **Heart Transplant**
- ☐ **Joint Replacement Knee (Right, Left, Bilateral) Date:_____**
- ☐ **Joint Replacement Hip (Right, Left, Bilateral) Date:_____**
- ☐ **Other Joint Replacement**
- ☐ **Kidney Biopsy (Nephrectomy)**
- ☐ **Kidney Removed**
- ☐ **Kidney Stone Removal**
- ☐ **Kidney Transplant**
- ☐ **Ovaries Removed: Endometriosis**
- ☐ **Ovaries Removed: Cyst**
- ☐ **Ovaries Removed: Ovarian Cancer**
- ☐ **Prostate Removed: Prostate Cancer**
- ☐ **Prostate Biopsy**
- ☐ **TURP (Prostate Removal)**
- ☐ **Spleen Removed**
- ☐ **Testicles Removed (Right, Left, Bilateral)**
- ☐ **Hysterectomy(Fibroids or Uterine Cancer)**
- ☐ **NONE**

Other: _____

Skin Disease History: (please check all that apply)

- ☐ **Melanoma**
- ☐ **Squamous Cell Skin Cancer**
- ☐ **Pre-Cancerous Moles**
- ☐ **Basal Cell Skin Cancer**

Other: _____

_____

Do you have any 1st degree relatives who have had Melanoma or any other skin cancers? If yes please list below

_____

_____

1. Is it possible you are pregnant? **Yes or No**

2. Are you breast feeding? **Yes or No**

HEIGHTS DERMATOLOGY AND LASER

FOR INSURANCE PURPOSES

Your insurance company requires the following intake form to be completed in order to provide you with the best care possible.

Please answer the following questions so we can comply with insurance guidelines at our practice.

Name:_____**DOB:**_____ **Date**_____

1. **Do you have any of the following conditions (please check all that apply)**
   - ☐ **Heart Failure**
   - ☐ **Coronary Artery Disease**
   - ☐ **Chronic Obstructive Pulmonary Disease (COPD)**
   - ☐ **Diabetes**
2. **Did you receive the Flu vaccine before this past Flu season?**
   - ☐ **Yes**
   - ☐ **No**
3. **Have you ever received the pneumonia vaccine?**
   - ☐ **Yes**
   - ☐ **No**
4. **Do you have a history of Melanoma?**
   - ☐ **Yes**
   - ☐ **No**
5. **Do you smoke?**
   - ☐ **Yes**
   - ☐ **No**
6. **Number of Alcoholic beverages consumed per day?**
   - ☐ **None**
   - ☐ **Less than 1 per day**
   - ☐ **1-2 per day**
   - ☐ **3 or more per day**
7. **Primary Care Physician Name:** _____

   Date of last physical exam (mm/yy):_____