INTAKE SHEET

Name: ______________________________________ Name you prefer to be called: _____________________
DOB: _______________ Age:____ ☐MALE ☐FEMALE Email: __________________________________
Address: ____________________________________ City: _________________ State: ____ Zip: _________

☐ New patient ☐Established patient, last seen:____
Check (✓) preferred phone:
☐ Cell: ________________________ ☐ Home: _____________________ ☐ Work: ____________________
Marital Status: ☐S ☐M ☐Other Spouse's name: ____
Other family members seen in this office: ____
How did you find out about us? ____
Employer (if self, name of business): ____
What do/did you do for work: ____
Any outdoor hobbies: ____
Do you use facial sunscreen? ☐ rarely ☐ intermittently ☐ everyday ☐ every 2 hours while in the sun
Chronic medical conditions (such as diabetes, high blood pressure, psoriasis): _________________________
____
____
History of HIV: ☐ yes ☐ no History of Hepatitis C (HCV): ☐ yes ☐ no
Smoking history: ☐ never smoked ☐ formerly smoked ☐currently smoke Number of years:________
Medication allergies: ____
Medicines you take (including vitamins, birth control, and herbal supplements):
____
____
History of skin cancer (type, location, year, treatment): ____
____
____
Family history of melanoma: ☐ yes ☐ no Relation to you: __________________________________
Primary or Referring MD: ____
Preferred Pharmacy: ____
Please describe the concern that brings you in today (where, how long, symptoms, what you have tried):
____
____
Other than what brought you in today, please check any services that may interest you (✓ all that apply):

___ Full skin exam/mole check
___ Professional skincare products
___ Sunscreen recommendations
___ Holistic, natural remedies
___ Skin tag removal
___ Hand rejuvenation
___ Torn/stretched earlobe repair
___ Chemical Peels
___ Sunspot treatment
___ Treatment of fine lines + wrinkles
___ Sclerotherapy for spider veins
___ Eyelash enhancement

OFFICE POLICY: Assignment of Benefits – Financial Agreement – I hereby give lifetime authorization for payment of insurance benefits to be made directly to Zand Dermatology, Inc. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and the reasonable attorney's fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Date: ______________________ Your Signature: ____