Please be sure to fill out all information and sign. Payment is expected at time of service. If you have any questions, please speak with the receptionist. Thank you.
***Any record requested or sent by other Physicians **will not** be stored/kept in our office.*

Patient Registration

Today's Date:_______________________

Name (First, Middle, Last): ____

Mailing Address: ____

City: _________________________ State: ______________ Zip: ____________________

DOB: ______________ SSN: ___________________ Sex: (M) (F) Marital Status: (S) (M) (D) (W)

Email: ____

Are you of Hispanic or Latino decent? (Yes) (No) If yes, from what region? ___________________

*****Please circle the below number at which you would prefer us to leave messages.*****

Home: _________________ Mobile: _________________ Work: ____________________

Do we have permission to?

- Discuss your medical condition with a family member? ☐Yes ☐No
- Leave a message with Pathology/Lab results? ☐Yes ☐No
- Permission to send appointment reminders by email? ☐Yes ☐No
- Permission to access your medication list from the national database? ☐Yes ☐No

Emergency Contact Information

Contact Name: _______________________________ Relationship to Patient: ____________________

Home: _________________ Mobile: ___________________ Work: __________________

If Minor

Parent/Guardian: _______________________________ Relationship to Patient: __________________

Occupation *If minor provide parents*

Position____

Employer Name: ____

Address: ____

City: ____________________________ State: ________________ Zip: ____________________

PLEASE TURN OVER →

Referring/Primary Doctor

Primary/Referring Physician: ____

Primary Health Insurance Information

Insurance Company: ________________________ ID# _________________ Group # __________

Patient's Relationship to Insured Party: (Self) (Spouse) (Child) *SSN is required for Primary Holder*

Name of Policy Holder: _______________________________ DOB: ________SSN:_____________

Address: _____________________________City:________________State:________Zip:________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: _______________

Employer: ________________________________ Occupation: ______________________________

Secondary Insurance Information:

Insurance Company: ________________________ ID# _________________ Group # ___________

Patient's Relationship to Insured Party: (Self) (Spouse) (Child)

Name of Policy Holder: _______________________________ DOB: __________SSN:____________

Address: _____________________________City:________________State:________Zip:_________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ________________

How did you hear about us?

Doctor: ______________Insurance:_______________ Patient: ______________Other:_____________

Pre-Authorized Healthcare Form

I authorize Davidson Dermatology to keep my signature on file and to charge my credit card account as indicated below:

Check one: ___ MasterCard ___Visa ____Discover ___American Express

___Balance of charges not paid by insurance within 90 days and not to exceed $__________

___this visit only

___all visits this year

___Recurring charges (on-going treatments) of $__________every ________from to_______/_______.
(frequency) (date) (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid unless I cancel the authorization through written notice to the healthcare provider.

Patients Name: ___________________________Cardholder Name: _____________________________

Account Number: ____

Expiration (Month/Year): ________________________ Zip Code: ______________________________

Signature: ____________________________________Date: _______________

Please sign even if you do not provide credit card.

HEALTH INFORMATION

Name: ______________________________ Date of Birth: _________________________

Reason for Visit

What brings you to the office today?

____

____

____

What cosmetic services are you interested in?

☐ Facial Fillers ☐ Sculptra ☐ Neurotoxin (Botox, Xeomin, Dysport) ☐ Revision Skin Care
☐ Laser Skin Treatments ☐ Laser Hair Removal ☐ Sunscreens ☐ Make-up, Jane Iredale

Review of Systems

Check those that apply:
☐ Bleeding Disorder Describe: ____
☐Pacemaker or Implanted Device Describe: ______________________________________
☐Do you require antibiotics prior to dental procedures due to a heart murmur?
☐Pregnant
☐Nursing
☐Trying to conceive

Past Medical History

Have you ever had any of the following?

☐Acne
☐Actinic Keratosis
☐Allergies
☐Arrhythmia
☐Arthritis
☐Asthma
☐Atopic Dermatitis
☐Atypical Nevi
☐Chronic Kidney Disease
☐COPD (Chronic Obstructive Pulmonary Disease)
☐Diabetes
☐Drug Dependency
☐Heart Failure
☐Hepatitis
☐Herpes Simplex Virus
☐Immune Disorder such as rheumatoid or psoriatic arthritis
☐High Blood Pressure
☐HIV
☐Keloid/Hypertrophic Scar
☐Loss of toe, foot, ankle or leg
☐Mood Disorder
☐Obesity
☐Psoriasis
☐Rosacea
☐Shingles
☐Skin Cancer:
- ☐Unknown
- ☐Basal Cell Carcinoma
- ☐Squamous Cell Carcinoma
- ☐Melanoma
- ☐Merkel Cell Carcinoma

Family History

Has anyone in your family ever had any of the following conditions?

☐Unknown-Adopted
☐Allergies
☐Asthma
☐Atopic Dermatitis
☐Autoimmune Disorders
☐Diabetes
☐Psoriasis
☐Skin Cancers:
- ☐Unknown Type
- ☐Basal Cell Carcinoma
- ☐Squamous Cell Carcinoma
- ☐Melanoma
- ☐Merkel Cell Carcinoma

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Family History continued…

Any other family history that you think we should know of?
Details:____
____
____

Lifestyle Factors

Have you ever smoked? ☐Yes ☐No # of years_________________ # of packs/day________________
Do you smoke now? ☐Yes ☐No

Current Medications

ALL medications including over the counter and/or supplements?
____
____
____
____

Allergies

Are you allergic to any of the following?
☐Lidocaine ☐Latex ☐Adhesive Tape

Please list any and all allergies to medications:
____
____
____
____

Vaccinations

Influenza Immunization? ☐Yes ☐No If yes: date: (Month/Year) ______________________________

Pneumococcal Vaccination? ☐Yes ☐No If yes: date: (Month/Year) ____________________________

Shingles Vaccination? ☐Yes ☐No If yes: date: (Month/Year) ________________________________

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Pharmacy Information

Pharmacy Name: ________________________ Pharmacy Location: ____________________________

Insurance Preferred Laboratory:

____

Signature: ____

Date: ____

Medical Assistant: ____