MGMD

Advanced Science for Beautiful Skin

MGMD Dermatology ▪ Michele Grodberg MD & Associates

REGISTRATION **TODAY'S DATE** ________________

Name (First)______________________________ (Last)___________________________________

Mailing Address________________________________ City __________ State ___ Zip Code ________

Home Phone________________ Work Phone ________________ Cell Phone __________________

Email Address____ SS#_______________________

Date of Birth____________ Age _____ Sex M F Marital Status - S M W D DP

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name (First)______________________________ (Last)___________________________________

Mailing Address________________________________ City __________ State ___ Zip Code ________

Home Phone________________ Work Phone ________________ Cell Phone __________________

Date of Birth______________ Sex M F Social Security # ____________________________

INSURANCE INFORMATION (Please present insurance card at time of check in so copies can be made)

Primary Insurance Name_________________	Secondary Insurance Name _____________
Name of Insured ______________________	Name of Insured ____________________
Date of Birth of Insured ________________	Date of Birth of Insured ______________
Relationship of patient to Insured __________	Relationship of patient to Insured __________

In Case of Emergency, who should be notified?______________________ Phone # _______________

Referred by: ____

Primary Care Physician ____
Name Address and/or Phone # if known

AUTHORIZATION, ASSIGNMENT AND ACKNOWLEDGEMENT

I hereby authorize the release to all my medical carriers of all information needed to substantiate payment for my medical care. A photostatic copy of this signature may be used as a substitute for the original.

I hereby authorize payment of medical benefits to the physician when an assigned claim is filed. I understand that I am responsible for my bill, including payment for non-covered services. A photostatic copy of this signature may be used as a substitute for the original.

A copy of the Office's Notice of Privacy Practices has been made available to me.

Patient/Responsible Party Signature____________________________________ Date ___________

FORM 191524 R/11/15 ITEM 8101

Dermatology Medical History

Patient: ______________________ Date: ____/____/____

Reason for today's visit: ______________________

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:
1. ______________ 2. ______________

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins and herbals):
1. ______________ 3. ______________ 5. ______________
2. ______________ 4. ______________ 6. ______________

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: ______________________

List surgical procedures you have had in the last 6 months: ______________________

Skin:

Have you ever had skin cancer? ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO
Do you have a history of any specific skin diseases? ☐ YES ☐ NO If yes, ______________
Do you have problems with healing? ☐ YES ☐ NO
Do you develop keloids (scars) after surgery? ☐ YES ☐ NO
Do you bleed easily? ☐ YES ☐ NO
Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment? ______________

Social History:

Do you drink alcohol? ☐ YES ☐ NO If YES, ________ drinks per day
Do you use IV drugs? ☐ YES ☐ NO If YES, what? ______________ How often? ______________
Do you smoke? ☐ YES ☐ NO If YES, how much: ______________
Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: ___/___/___
What is your occupation? ______________________ Hobbies? ______________

Completed by: ☐ Patient
☐ Medical Assistant ________ Initials

______________________ Signed by Patient ___/___/___ Date

______________________ Reviewed by ___/___/___ Date