ASTORIA DERM

ALEXANDER NICOLAIDES M.D

BOARD CERTIFIED DERMATOLOGIST

FULL NAME: _____ DOB: _____ DATE: _____

REASON FOR TODAYS VISIT: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☐

IF YES PLEASE LIST: _____

_____

ARE YOU CURRENTLY TAKING ANY ASPRIN PRODUCTS? YES ☐ NO ☐ IF YES, WHAT KIND? _____

HAVE YOU EVER HAD A FULL BODY/ MOLE EXAMINATION? YES ☐ NO ☐

MEDICAL HISTORY

PLEASE APPLY A CHECK (✓) NEXT TO ANY CONDITIONS THAT APPLY TO YOU:

___ ACNE
___ ACTINIC KERATOSES
___ ALLERGIES
___ ASTHMA
___ BASAL CELL CANCER
___ BLADDER DISORDER
___ BLISTERING SUNBURNS
___ BLOOD CLOTS
___ DIABETES
___ DRY SKIN
___ ECZEMA
___ EMPHYSEMA
___ EPILEPSY/ SEIZURES
___ FLAKING/ ITCHY SCALP
___GASTROINTESTINAL DISORDER
___ HEART ATTACK
___ HEART MURMUR
___ HIGH BLOOD PRESSURE
___ KIDNEY DISORDER
___ MELANOMA
___ PHLEBITIS
___ POISON IVY
___ PRECANCEROUS MOLES
___ PSORIASIS
___ SQUAMOUS CELL SKIN CANCER
___ THYROID DISORDER

-DO YOU DRINK? YES __ NO __ / IF YES __ DRINKS PER DAY
-DO YOU SMOKE? YES __ NO __ / IF YES HOW MUCH _____
-HAVE YOU EVER BEEN EXPOSED TO HIV (AIDS)? YES__ NO __
-DO YOU BLEED OR BRUISE EASILY? YES__ NO __
-DO YOU TAKE ANY ANTIBIOTICS BEFORE DENTAL OR SURGICAL PROCEDURES? YES __NO__
IF YES WHAT KIND _____
- (WOMAN) ARE YOU CURRENTLY PREGANANT OR PLANNING? YES__ NO __
- HAVE YOU EVER HAD SKIN CANCER? YES__ NO __
- HAS ANYONE IN YOUR FAMILY HAD SKIN CANCER? YES__ NO __ IF YES, PLEASE LIST RELATION AND TYPE OF CANCER _____

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DEMOGRAPHIC INFORMATION

SEX
MALE ☐ FEMALE ☐

LAST NAME:	FIRST NAME:	MIDDLE NAME:
STREET ADDRESS:	CITY/STATE/ZIP:	DATE OF BIRTH:
HOME PHONE:	CELL PHONE:	BUSINESS PHONE:

PATIENTS OR PARENTS EMPLOYER:	OCCUPATION (INDICATE IF STUDENT):	EMAIL:
REFFERING DOCTOR:	REFFERING DOCTOR PHONE NUMBER:	SOCIAL SECURITY NUMBER:

INSURANCE INFORMATION

INSURED/ PARTY RESPONSIBLE:	ADDRESS (IF DIFFERENT FROM ABOVE):	RELATIONSHIP:
		INSURED'S DOB: / SS# OF INSURED:
PRIMARY INSURANCE COMPANY:	MEMBER ID:	GROUP NUMBER:
SECONDARY INSURANCE:	MEMBER ID:	GROUP NUMBER:

EMERGENCY CONTACT

NAME:	PHONE NUMBER:	RELATIONSHIP:
NAME:	PHONE NUMBER:	RELATIONSHIP:

Date ____ / ____ / _____

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BOARD CERTIFIED DERMATOLOGIST

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____

_____

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS:

_____

_____

_____

_____

CURRENT MEDICATIONS:

_____

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SURGICAL HISTORY:

_____

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ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself/and or dependents. I further expressly agree and acknowledge that my signature authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted on my/and or dependents behalf until such authorization is revoked by me in writing.

I hereby authorize my insurance provider to pay and hereby assign directly to Dr. Alexander Nicolaides all benefits, if any, otherwise to me for these services. I understand I am responsible for all charges incurred. I further acknowledge that my insurance benefits when received by and paid to Dr. Nicolaides will be credited to my account, in accordance with the above assignment.

PATIENT SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review a copy of the Notice of Privacy Practices in office or on the ASTORIADERM.COM website which I have read and understood.

PRINT PATIENT NAME: _____ **DATE:** _____

PARENT OR AUTHORIZED

REPRESENTATIVE (IF UNDER 18): _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____