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PLEASE GIVE US YOUR INSURANCE CARD TO BE PHOTOCOPIED

Please print clearly

Patient's name: _____ Date: _____

Address: _____ Home phone: _____

City: _____ State: _____ Zip: _____

Patient's occupation: _____ S.S.#: _____

Employer: _____ Business phone: _____

Employer's address: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ Sex: _____ Marital status: S M W D Sep (circle one)

If married, name of spouse: _____

Person responsible for payment: _____ Relationship: _____ Birthdate: _____

Address of responsible person: _____ State: _____ Zip: _____

Whom may we thank for referring you to us? _____

Family or personal physician: _____

Whom may we contact in case of emergency? _____ Phone: _____

INSURANCE INFORMATION
(Please check appropriate line)

***We are participating with Medicare and Blue Shield; however, certain plans require patients to pay deductible, co-insurance or eligible services

Insurance company name: _____

Group no: _____ Identification No: _____

Subscriber: _____ (name of person carrying insurance)

Subscriber's SSN (if other than patient): _____ Subscriber's birthdate: _____

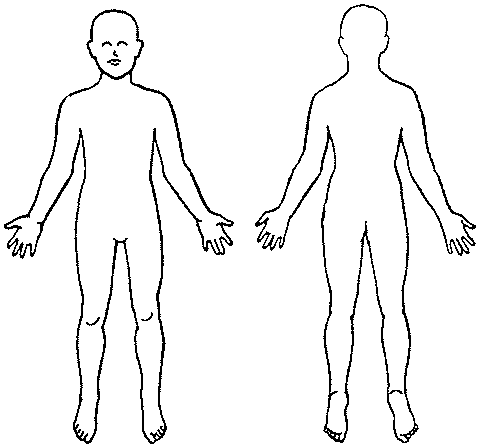
Lab to use: _____

BRIEF MEDICAL HISTORY

What is your present complaint?
(Rash, Acne, Growth, Scalp, Hair, etc.) _____
_____
_____
_____

When did you first notice this problem? _____
_____
_____
_____

Please indicate on the figures here where your present skin problem is by marking an "X" on the body sketch



Yes	No	
____	____	Does your skin react to anything (tape, jewelry, perfume)?
____	____	Please list: _____
____	____	Are you allergic to any medications?
____	____	Please list: _____
____	____	(For female patients only) Are you now pregnant?

→ **PLEASE ANSWER QUESTIONS ON REVERSE SIDE**

Yes	No		Yes	No	
____	____	Allergic reaction to Novocaine or Xylocaine?			
____	____	Family history of melanoma?			
____	____	Blood transfusion within the past 10 years?			
____	____	X-ray treatment for acne or eczema?			
____	____	Are you HIV-positive?			
____	____	Do you have AIDS?			
____	____	Arthritis?	____	____	Heart disease?
____	____	Asthma?	____	____	Hepatitis or liver disease?
____	____	Bleeding problem?	____	____	High blood pressure?
____	____	Cancer?	____	____	Kidney problems?
____	____	Skin cancer?	____	____	Psoriasis?
____	____	Diabetes?	____	____	Thyroid disease?
____	____	Eczema?	____	____	Ulcers?
____	____	Hay fever?			
____	____	Other?			

Are you under the treatment of a doctor? _____

Reason: _____

MEDICINES

Has a doctor given you anything for your skin? If yes, please list t6he names of everything you have been given:

_____

_____

_____

Have you put anything else on your skin yourself? (Non-prescription drugs, lotions, creams, etc.) Please list the names of everything you have used on it: _____

Do you take any of the following? If so, give name of drug:

Yes	No		
____	____	Steroids?	_____
____	____	Aspirin or pain pills?	_____
____	____	Nerve pills / sedatives?	_____
____	____	Laxatives?	_____
____	____	Birth control pills?	_____
____	____	Anticoagulants (blood thinners)?	_____

Please list all other medication that you are presently taking: _____

_____

_____

IN ORDER TO SUBMIT A CLAIM TO YOUR INSURANCE CARRIER, IT IS NECESSARY THAT THE PATIENT, OR PERSON ACTING ON HIS OR HER BEHALF, SIGN THE FOLLOWING AUTHORIZATION:

"I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO MY MEDICAL INSURANCE CARRIER OR TO ITS INTERMEDIARIES, OR TO THE BILLING AGENT OF THIS PHYSICIAN OR SUPPLIER WHICH IS CHERYL D. ACKERMAN, M.D., ANY INFORMATION NEEDED FOR THIS OR A RELATED CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT."

_____ _____

SIGNATURE DATE RELATIONSHIP, IF OTHER