LANCERx dermatology
A FOREFRONT DERMATOLOGY PRACTICE

Name: _____
Last Name First Middle Initial

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____ DL#: _____

Home Address: _____

Cell #: _____ Home#: _____ Work#: _____

Email Address: _____@_____

Occupation: _____ Work address: _____

Nearest Relative Living with You: _____ Phone#: _____
(Or nearest not living with you, if above does not apply)

Whom we may contact, in an emergency? _____

Day Phone: _____ Night Phone: _____

Primary Physician: _____ Phone: _____

Whom We May Thank for Referring You to Us? _____

Primary Method of Payment: Check _____ Cash _____ Credit Card _____

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Name: _____
Last Name First Middle Initial

ETHNICITY
☐ Asian ☐ African American ☐ North African ☐ Middle Eastern ☐ Celtic
☐ Northern European ☐ Southern European ☐ Native American ☐ Latin

1. Are you sensitive or ALLERGIC to any drugs /medications? Yes / No
   If yes, please list: _____
2. Have you had any excessive bleeding requiring medical treatment? Yes / No
   If Yes, please list: _____
3. Are you under the care of a dermatologist? Yes / No
   If Yes, please list: _____
4. Are you under the care of a Physician (including family doctor and PCP's) Yes / No
   If Yes, please list: _____
5. Are you using any drugs or medications? Yes / No
   If Yes, please list: _____
6. Are you currently having Facials? Yes / No
   If Yes, please list: _____
7. Have there been any changes in your General Health within the past year? Yes / No
   If Yes, please list: _____
8. Have you ever had Heart Surgery, MVP or Heart Ailments? Yes / No
   If Yes, please list: _____
9. Have you ever had any serious Illness, Surgery or Hospitalization? Yes / No
   If Yes, explain the reason and the admission date _____
10. Date of your last Physical Exam? _____
11. Women: Are you Pregnant or Nursing? Yes / No
    If Yes, please list which is applicable and number of months: _____
12. Do you smoke tobacco now, or in the past? Yes / No
    If Yes, how long? _____
13. Do you wear Glasses or Contact Lenses? Yes / No
    If Yes, please list which is applicable and how often: _____
14. Do you have or have had any of the following?

( ) Anxiety	( ) Epilepsy	( ) Radiation Treatment of any kind
( ) Artificial Joints	( ) Excessive Bleeding	( ) Respiratory Disease
( ) Asthma or Hay Fever	( ) Eye Trouble	( ) Rheumatic Disease
( ) Blood Disease	( ) Fainting Spells or Seizures	( ) Skin Diseases
( ) Cold Sores or Herpes	( ) Frequent or severe headaches	( ) Stroke
( ) Depression	( ) Hepatitis, Jaundice, Liver Disease	( ) Tumors
( ) Diabetes	( ) Kidney Disease	( ) Venereal Diseases

15. Do you have a disease or condition not indicated above which you feel we should know about?
    Please explain: _____

I authorize pictures to be taken before, during and after the procedure. These pictures and digital images will become part of your medical record and may be used or disclosed as permitted by HIPAA.

Signed: _____ Date: _____