MGMD
ADVANCED SCIENCE FOR BEAUTIFUL SKIN
MGMD Dermatology ▪ Michele Grodberg MD

Patient Name: _____ **Date:** _____
Date of Birth: _____ **Age:** _____ **SS#:** _____ **Male or Female**
Address: _____
City: _____**State:** _____**Zip Code:** _____
Home Phone: (____) _____ **Cell Phone:**(____) _____
E-Mail*: _____**Business Phone:** (_____) _____
*By providing my email I authorize MD to send me promotional emails and web-enable me with the practice, I understand that I can unsubscribe at any time.

Employer Name: _____**Occupation:** _____
Primary Doctor: _____ **Referring Doctor:** _____
Primary Pharmacy: _____
How did you hear about our practice? (Circle all that apply)
Referring Physician Website Social Media Print Family/Friend:

Emergency Contact Information

Name: _____
Relationship: _____Phone: _____
Subscriber of Insurance Information **Is Guarantor the same as Subscriber?** □Yes □No

Name: _____ Relation to Patient: _____ D/O/B: _____

Address (If different from above): _____
I agree that my Protected Health Information (PHI) may be shared with the following people:
_____ _____

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**_____

MGMD Dermatology
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Dermatology Medical History

Patient Name: _____ 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. _____

Have you ever had or been treated for any of the following? (Circle all that apply)

- ☐ Excessive sun exposure in childhood
- ☐ Sunburns
- ☐ Melanoma
- ☐ Skin cancer
- ☐ Keloids or excessive scars
- ☐ Allergy to local anesthetics
- ☐ Excessive bleeding
- ☐ Difficulty with healing
- ☐ Psoriasis
- ☐ Liver disease
- ☐ Lung disease
- ☐ Heart disease
- ☐ High blood pressure
- ☐ HIV
- ☐ Hepatitis B or C
- ☐ Kidney disease
- ☐ Venereal disease
- ☐ Cancer (other than skin)
- ☐ Neurological disorder
- ☐ Emotional or psychiatric problem
- ☐ Blood or lymph gland disorder
- ☐ Arthritis, joint problem, or bone disease
- ☐ Diabetes
- ☐ Ulcer or intestinal disease
- ☐ Conditions requiring prophylactic antibiotics

Other conditions (please specify) _____

Have you previously had a skin problem or been under the care of a dermatologist? (If yes, please describe)

_____

Please list any other disease or conditions: _____

Prior hospitalization or surgery (Please specify surgery and dates)

_____

Have any members of your **family** had, specify who: (Circle all that apply)

- ☐ Asthma/Hay fever/Eczema
- ☐ Clotting disorder
- ☐ Autoimmune disorder
- ☐ Other conditions (please specify) _____
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Skin Cancer

Signature: _____ **Date:** _____