KLEYDMAN DERMATOLOGY

Patient Information **Date of Appointment: _____**

Patient's First Name	Patient's Last Name			
Date of Birth	SSN		Sex (please circle) M F	
Address	Apt #	City	State	Zip
Home Phone	Cell Phone			
Email Address				
Primary Care Physician	Primary Care Physician Phone			
Pharmacy	**Pharmacy Phone**	**Pharmacy Address**		

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone
Relation to Patient	

Referral Information

Please check off how you found out about our office

____Doctor ____ZocDoc ____Facebook ____Insurance Search ____Family/Friend ____Magazine

Cancellation Policy

I understand and agree that it is my responsibility to notify Kleydman Dermatology **24 hours prior** to the scheduled appointment if I am unable to keep the scheduled appointment. I understand and agree that I will be billed the contracted rate of **$25 for regular visit** and **$50 for cosmetic and/or surgical appointment** in the event that I miss the appointment and/or fail to notify the office at least 24 hours in advance.

Patient Name: _____ Signature: _____ Date: _____

Legal Guardian Name: _____ Signature: _____ Date: _____

KLEYDMAN DERMATOLOGY

Reason for today's visit: _____

Medical History

Have you ever experienced any of the following?

YES ❑ NO ❑ Skin Cancer
Рак Кожи

YES ❑ NO ❑ Melanoma
Меланома

YES ❑ NO ❑ Actinic Keratosis
Предраковые Заболевания Кожи

YES ❑ NO ❑ Arthritis
Артриты

YES ❑ NO ❑ Eczema
Экзема

YES ❑ NO ❑ Psoriasis
Псориаз

YES ❑ NO ❑ Asthma
Астма

YES ❑ NO ❑ Bleeding Issues
Повышенное Кровотечение

YES ❑ NO ❑ Clotting Issues
Проблемы Свертываемости Крови

YES ❑ NO ❑ Keloids
Келоидные Шрамы

YES ❑ NO ❑ Autoimmune Disease
Аутоиммунные Заболевания

YES ❑ NO ❑ HIV/AIDS/Hepatitis B/Hepatitis C
ВИЧ / СПИД / Гепатит В / Гепатит С

YES ❑ NO ❑ Diabetes
Сахарный Диабет

YES ❑ NO ❑ Thyroid Disease
Заболевания Щитовидной Железы

YES ❑ NO ❑ Kidney Disease
Заболевания Почек

YES ❑ NO ❑ High Blood Pressure
Гипертоническая Болезнь

YES ❑ NO ❑ Heart Attack or Stroke
Инфаркты / Инсульты

YES ❑ NO ❑ Artificial Heart Valve
Искусственный Клапан Сердца

YES ❑ NO ❑ Pacemaker
Кардиостимулятор

YES ❑ NO ❑ Defibrillator
Дефибриллятор

YES ❑ NO ❑ Organ/Bone Marrow Transplant
Трансплантация Органа

YES ❑ NO ❑ Artificial Joint
Искусственный Сустав

Female patients: Are you pregnant? Nursing? Trying to get pregnant? YES ❑ NO ❑

Have you ever had an allergic reaction to (circle**): Latex / Lidocaine / Epinephrine / Iodine / Adhesives**

Please list any medications/products you are allergic to: _____

_____

List all medications you are currently taking (including prescriptions, over-the-counter meds, Vitamins, and herbals):

1._____ 3._____ 5. _____

2._____ 4._____ 6. _____

Please list any surgeries you previously had: _____

_____

Tobacco Use: YES ❑ NO ❑ Occasionally ❑ Alcohol Use: YES ❑ NO ❑ Occasionally ❑

Patient Name: _____ Signature: _____ Date: _____

Legal Guardian Name: _____ Signature: _____ Date: _____