Greenbrae Dermatology

Benjamin Nichols, MD • Cheryl Tanasovich, MD • John Maddox, MD

Name: ______________________________ Name you prefer to be called: ____________

Date of Birth: ____________________ ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Other: ____________ Language: ____________

SSN#: ______________________________ Driver's Lic #: ______________________________

Address: ________________________ City: ____________________ State: ________ Zip: ________

Race: ☐American Indian or Alaska Native ☐Asian ☐African American ☐Caucasian ☐Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐Other Race ☐Unknown ☐Decline to specify

Check preferred phone:

☐Cell: ____________________ ☐Home: ____________________ ☐Work: ____________________

Is it okay to leave a detailed message on your phone? ☐YES ☐ NO ______ Initial

Email: ______________________________

Preferred Reminder Notifications: ☐Email Reminder ☐Phone (Voice) Reminder ☐ Phone (Text) Reminder

Employer (Name and nature of business): ______________________________

Primary Insurance Subscriber: ☐ Self ☐ Other	**Emergency Contact:**
(if checked "Other", please fill out below)	Relationship to Contact: ____________
Relationship to Subscriber: ____________	First Name: ____________
Name (First & Last): ____________	Last Name: ____________
Address: ____________	Zip/Postal Code: ____________
City: ____________ State: ________ Zip: _____	Phone #: ____________
Phone #: ____________ Date of Birth: ________	

OFFICE POLICY: Assignment of Benefits - Financial Agreement - I hereby give lifetime authorization for payment of insurance benefits to be made directly to Greenbrae Dermatology, A Medical Corporation. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and the reasonable attorney's fees. I hereby authorize the health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Date: ____________________ Your Signature: ______________________________

Past Medical History: (Please circle all those applies)

Anxiety	Depression	HIV/AIDS	Prostate Cancer
Arthritis	Diabetes	High Cholesterol	Radiation Treatment
Asthma	End Stage Renal Disease	Hyperthyroidism	Seizures
Atrial Fibrillation	GERD	Hypothyroidism	Stroke
Transplant: ___________	Hearing Loss	Leukemia	Other:_______________
Breast Cancer	Hepatitis:_____________	Lung Cancer	____________________
Colon Cancer	High Blood Pressure	Lymphoma	____________________

Past Surgical History: (Please circle all that applies)

Breast Cancer	Joint Replacement, Hip (R / L / B)	Prostate Removed: Prostate Cancer
Coronary Artery Bypass	Kidney Removed (Right / Left)	Spleen Removed
Mechanical Valve Replacement	Kidney Transplant	Uterine Cancer
Heart Transplant	Liver Transplant	Cervical Cancer
Joint Replacement, Knee (R / L / B)	Ovaries Removed: Ovarian Cancer	Other:_________________________

Skin Disease History: (Please circle all that applies)

Acne	Basal Cell Skin Cancer	Eczema	Poison Oak
Actinic Keratoses	Blistering Sunburns	Flaking or Itchy Scalp	Precancerous Moles
Asthma	Dry Skin	Hay Fever / Allergies	Psoriasis
Other:____________________________________		Melanoma	Squamous Cell Skin Cancer

Do you wear sunscreen? ☐ YES ☐ NO If yes, what SPF? ___________
Do you use tanning beds? ☐ YES ☐ NO
Do you have a Family History of Melanoma? ☐ YES ☐ NO If yes, which relative(s)?:____________________
Are you pregnant or currently breast feeding? ☐ YES ☐ NO

Medications: (Please enter all current medications or provide a list if available)

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____

Allergies: (Please enter all medication allergies & reactions)

____

____

Cigarette Smoking: ☐Daily ☐Some days ☐Former smoker ☐Never smoked

Family History of Cancer (Only 1st degree relatives & type): ______________________________________

Preferred Pharmacy:_____________________________	**Primary Care Physician:**_____________________
City:_________________ Street/Location:_____________	Phone:_______________________________________