



Mid-Florida Dermatology Associates

Dermatology and Dermatological Surgery

ORLANDO
100 W. Gore St. #600
Orlando, FL 32806
407.299.7333

WATERFORD LAKES
829 Woodbury Rd. # 103
Orlando, FL 32828
407.299.7333

METROWEST
7652 Ashley Park Ct. #305
Orlando, FL 32836
407.299.7333

NEW SMYRNA BEACH
519 North Dixie Freeway
New Smyrna Beach, FL 32168
386.428.2223

PATIENT REGISTRATION FORM

Patient Information

Account #: _____ Gender: _____ Marital Status: _____

Last Name: _____ Date of Birth: _____ Age: _____

First Name : _____ Initial: _____ Social Security Number: _____

Address : _____ Home Phone: _____

City, State & Zip _____ Work Phone : _____

Employer: _____ Referring Dr: _____

Address : _____ Address : _____

City, State & Zip _____ City, State & Zip _____

Responsible Party

Account #: _____ Relationship to Patient: _____

Last Name: _____ Gender: _____ Marital Status: _____

First Name : _____ Initial: _____ Date of Birth: _____ Age: _____

Address : _____ Social Security Number: _____

City, State & Zip _____ Home Phone: _____

Employer: _____ Work Phone : _____

Address : _____

City, State & Zip _____

Primary Insurance Information

Primary Insurance: _____ Subscriber: _____

Address : _____ Insured Policy # _____

City, State & Zip _____ Group # _____

Telephone: _____ Date of Birth: _____

Effective Dates: _____ Patient Relationship to Subscriber: _____

Copay Amount: _____



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DERMATOLOGY HISTORY CHECKLIST

PATIENT NAME: _____ D.O.B. ____/____/____ DATE: ____/____/____

REASON FOR VISIT:

Have you had any previous treatment for this? If so, please list: _____

LIST THE MEDICATIONS YOU'VE TAKEN FOR THIS	EFFECTIVENESS

HEALTH QUESTIONNAIRE

MEDICAL HISTORY: Mark (C) for current problems. For past problems, indicate your age when you had any of the following symptoms or diseases in the line to the left of it.

- | | | |
|---------------------------|----------------------|--------------------|
| ____ HIV/AIDS | ____ CATARACTS | ____ ASTHMA |
| ____ GLAUCOMA | ____ HEART DISEASE | ____ PHLEBITIS |
| ____ JAUNDICE | ____ HEPATITIS | ____ PEPTIC ULCERS |
| ____ ANEMIA | ____ CANCER | ____ HYPERTENSION |
| ____ DIABETES | ____ SEIZURES | ____ ARTHRITIS |
| ____ ALLERGIES (NON-DRUG) | ____ THYROID DISEASE | ____ STROKE |

ANY OTHER CONDITION(S) NOT LISTED : _____

HOSPITALIZATION AND SURGICAL HISTORY: Please list any hospitalizations or surgical procedures that you have received and the year in which it occurred.

HOSPITALIZATION OR SURGICAL PROCEDURE	YEAR

DERMATOLOGICAL HISTORY: Mark (C) for current problems. For past problems, indicate your age when you had any of the following dermatological conditions in the line to the left of it.

- | | |
|-------------------------------------|------------------------------------|
| ___ ECZEMA | ___ PSORIASIS |
| ___ FREQUENT RASHES | ___ HEART DISEASE |
| ___ ABNORMAL MOLES | ___ FREQUENT SUN EXPOSURE |
| ___ EXCESSIVE SCARRING | ___ ACTINIC KERATOSIS "PRE-CANCER" |
| ___ NON-HEALING OR BLEEDING GROWTHS | |

HISTORY OF SKIN CANCER: Please check any of the following that apply. If any, please describe the type of treatment received in the space provided to the right.

- ___ BASAL CELL: _____
- ___ SQUAMOUS CELL: _____
- ___ MELANOMA: _____

When you are exposed to sunlight , do you:

- BURN
- BURN-TAN
- TAN ONLY

CURRENT MEDICATIONS: Please list all current medications that you are taking (including over-the-counter medications.):

MEDICATION NAME	STRENGTH	HOW OFTEN?

ANY ALLERGIES TO MEDICATIONS? _____