Grosse Pointe Dermatology Associates, P.C.

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Name _____ DOB _____ Todays Date_____
Last First M.I.

Address_____City_____Zip Code_____

Home Phone #:_____ Cell Phone #: _____

May we leave a message if we receive your voicemail? YES or NO (if YES please indicate what number we may leave a message at)

_____

Sex: _____ Marital Status: S_____M_____W_____D_____

E-Mail: _____@_____.com

Emergency Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

Name of insurance company: _____

Subscriber date of birth (if different than patient): _____ Relationship to patient: _____

**Please give your insurance card to the front desk so we can make a copy for our files.*

Responsible Party (if different from patient or patient is a minor)

Name: _____ Date of Birth: _____
Last First M.I.

Address (if different than patient):_____

Phone number: _____ Relationship to patient: _____

_____

Primary Care Providers Name: _____ Phone #: _____

Location: _____ last visit to PCP: _____

_____

Please Turn Over

→

Please fully complete all medical information

Have you been vaccinated for pneumonia? Yes No

Have you been vaccinated for the flu this year? Yes No

Have you been vaccinated for COVID? Yes No

If yes, circle which vaccine you received: Pfizer / Moderna / Johnson and Johnson

What was the month of your last dose? _____

Please circle what applies to you-

Kidney disease/ Liver disease / Diabetes / High blood pressure / Cardiovascular disease/ Blood clotting disorders/ Organ transplant/ Cancer/ Defibrillator/ Pacemaker/ HIV/ Blood thinners/ artificial heart valve/ Artificial joints within the last 2 years/ Pre-medicates prior to procedures/ Pregnancy or planning/ Breastfeeding/ Allergy to Lidocaine/ Rapid heart rate with Epinephrine/ Problems with healing

Do you have any allergies? If *yes*, please list them:

_____

Are you on any medications? If *yes*, please list them or provide a list to copy:

_____

_____

_____

I give you permission to discuss my protected health information with:
(Please list the name(s) of the person(s) you will allow our office to discuss your protected health information with. If no names are given and a person calls on your behalf without being listed on this form, we will NOT provide them with any information about yourself, including upcoming appointment times. Please add as many personal names as you need, you do not need to add physicians in this section.)

_____ _____

Name & Relationship **Name & Relationship**

I give Grosse Pointe Dermatology permission to speak to my pharmacy.

Address: _____

City/Zip code: _____

Pharmacy Name and phone number: _____

_____ _____

Please sign this line **Date**