EAST PENN DERMATOLOGY, P.C.

Michael B. Stierstorfer, M.D. Marvin Sasson, M.D.

TODAY'S DATE: _____

PATIENT NAME: _____ **BIRTH DATE:** _____

Last **First** **Middle** ***Full Time Student*****:** Yes No

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **Last 4 digits of SS#:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

SEX**:** *M F* ***MARITAL STATUS*****:** *M W D S* **E-MAIL:** _____

REFERRED BY: _____ **PATIENT'S OCCUPATION:** _____

FAMILY DOCTOR: _____

Location (Group name, address or phone number): _____

PERSON RESPONSIBLE (if other than patient)/**EMERGENCY CONTACT:** _____

Relationship to patient: _____ Phone Number: _____

If patient lives in a residential facility provide name and phone number: _____

_____

WHAT IS THE NATURE OF YOUR PROBLEM? _____

WHAT MEDICATIONS ARE YOU TAKING? _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? If so, what? _____

HAVE YOU HAD SURGERIES IN THE PAST? If so, what? _____

_____

DO YOU EVER BECOME LIGHTHEADED, SWEATY OR SICK TO YOUR STOMACH WHEN YOU HAVE BLOOD DRAWN? _____

PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY TO THE PATIENT:

____**Problems healing after surgery**	____**Anemia**	_____**Scarring or keloids**	____**Tobacco use**
____**High blood pressure**	____**Diabetes**	_____**HIV**	____**Alcohol use**
____**Pacemaker**	____**Asthma or hay fever**	_____**Cancer**	____**Hepatitis**
____**Heart murmurs**	____**Eczema**	_____**Skin cancer**	____**Ulcer disease**
____**Unusual bleeding**	____**Hives**	_____**Family history of skin cancer**	
____**Irritable Bowel Syndrome**	____**Memory problems**		

Patient's Signature* (or parent if patient is child):** _____ **Date:** _____

Reviewed by: _____ **Date:** _____

(Doctor's Signature)

AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS:

I authorize the release of any information including the records of any diagnosis, treatment or examination rendered to me or my child, to physicians and my insurance companies. I hereby assign all medical and/or surgical benefits to which I am entitled to East Penn Dermatology, P.C. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ **Date:** _____

**Patient's Signature* (or parent if patient is child)

MEDIGAP (Patients covered by Medicare and a secondary insurance)

I request that payment of authorized Medigap benefits be made on my behalf to East Penn Dermatology, P.C for any services furnished me. I authorize the holder of medical information about me to release to my insurance carrier any information needed to determine these benefits payable for related services.

Patient's Signature*: _____ **Date: _____

Form updated 1/20/16