Dermatology Medical History

Patient: _____ Date of Birth: ___/___/_____ Today's Date: __/___/___

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Chronic Cold Sores
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed, (Right, Left, Bilateral)
Hysterectomy: Fibroids
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other: _____

Do you wear sunscreen? Yes No If yes, what SPF? ____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes NO
If yes, which family relative(s)? _____
Any other Family history? _____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____

Social History: (please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Illicit Drug Use:
- Drug Use
- IV Drug Use

Alcohol Use:
- None
- Less than 1 drink a day
- 2-3 drinks a day
- 3 or more drinks a day

Safety:
- I feel safe at home
- I do not feel safe at home

Exercise:
- Several times a day
- Once a day
- Few times a week
- Few times a month
- Never

Caffeine Use:
- Several times a day
- Once a day
- Few times a week
- Few times a month
- Never

First Degree Relative Medical History: (Parents, Siblings or Children)

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- BPH
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Chronic Cold Sores
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Smoker
- Valve Replacement
- None

Other_____

PATIENT INFORMATION ☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: ***Please fill in all lines with an answer.***

If a question is not applicable please put N/A

Today's Date ___/___/____

Name _____ SS# _____

Last First M.I.

Date of Birth: ___/___/___ Age: _____ Sex: ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race _____ Ethnicity _____

Address 1 _____

Address 2 _____

City State Zip

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY ***(if different from patient)***

Name: _____ Date of Birth: ___/___/___

Last First M.I.

Address: _____

City State Zip

Home Phone: ( )_____ Work Phone: ( )_____

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?_____ Phone ( )_____

Relationship to patient: _____

Primary Care Physician _____ **Phone (** **)**_____

Last Name First Name

Preferred Pharmacy_____ **Phone (** **)**_____

NAME & LOCATION

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:_____

Address of Claim Center:_____

_____

City State Zip Code

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other_____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:_____

Address of Claim Center:_____

_____

City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____ Group Name or #:_____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other_____

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:_____ Today's Date ___/___/___

Other family members that are patients _____

Referred by: _____ Phone ( )_____

Last Name First Name

May we leave personal medical information on your answering machine at home?

☐ YES ☐ NO

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ Date ___/___/___

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services at the time of service.

Patient or Responsible Party Signature _____ Date ___/___/___

WARMUTH
INSTITUTE OF DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

420 Front Street
Elmer, NJ 08318

4 Bypass Road Suite 104
Salem, NJ 08079

95 Woodstown Road
Swedesboro, NJ 08085

856.358.1500 • 856.358.1117 (fax)
www.warmuthinstitute.com

Cancelation Policy

When you make an appointment with one of our providers, we set aside an appointment time specifically for you. If you miss an appointment, it can't be filled by another patient in need of our services. Therefore, any missed or canceled appointments within 24 hours will result in a $50.00 charge to be billed directly to the patient. ____ (please initial)

Thank you in advanced for your cooperation in this matter, and we look forward to providing you with the utmost in medical care.

Patient or Responsible Party Signature_____ Date___/____/_____

Receipt of Notice of Privacy Practice:

My signature below indicates that I have received and/or reviewed a copy of my physicians Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature_____ Date___/____/_____

Biopsy Results:

Please put the names of any person(s), that we will be able to discuss your medical information with.

I hereby give permission for the providers of Ingrid P. Warmuth, MD PA to discuss my biopsy results from all dates of service with the following people:

Name	***Birth Date***	***Telephone***

Signature **Date**

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Cosmetic Skin Care Form

Thank you for choosing Dr. Ingrid Warmuth Skin Care Center for your skin care needs. Our office provides high quality care and our philosophy is to actively listen to your needs and offer you the best care possible. In order to help us provide that care, please assist us by completing this form.

Name: _____ Email: _____

1. Describe your skin type: ❍ Normal ❍ Oily ❍ Dry ❍ Combination ❍ Sensitive
2. What skin care products are you currently using? _____

   _____
3. Do you experience any allergic reactions to any skin care products? ❍ No ❍ Yes

   _____
4. Are you interested in learning about:

   ❍ Botox/Dysport/Xeomin ❍ Fillers ❍ Chemical Peels ❍ Laser/Light Treatment
   ❍ Microdermabrasion ❍ Any Resurfacing Treatment ❍ Anti-Aging Treatments
   ❍ Skin Care ❍ Facials ❍ Makeup ❍ Acne Treatments
5. Please check any concerns you might have regarding your face or body rejuvenation:

   ❍ Wrinkles ❍ Acne ❍ Rosacea ❍ Opened Pores ❍ White/Black Heads
   ❍ Dark circles around eyes ❍ Skin Discoloration ❍ Sun Damage ❍ Broken Vessels
   ❍ Varicose Veins ❍ Excessive Hair Growth ❍ Hair Loss ❍ Tattoos ❍ Scarring
   ❍ Nail Changes ❍ Excessive Fat ❍ Stretch Marks ❍ Skin Atrophy/Thinning/Laxity
   ❍ Short Eye Lashes ❍ Thin Lips ❍ Other _____
6. Are you trying to become pregnant? ❍ Yes ❍ No

Please feel free to contact us at 856.358.1500 for a complimentary cosmetic consultation with one of our skin care specialists: Ingrid P. Warmuth MD PA, Daisy Fisher APN-C and Tina Hawk Aesthetic Director.

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Please tell us, did you hear about us...

Today's Date: _____

1. Through a patient? Please tell us who so we can thank them.

   _____

2. A referral from a family member or friend? Please let us know who.

   _____

3. A referral from your physician? Please tell us your doctor's first and last name.

   _____

4. An advertisement in the newspaper? Please circle which one:

   The Daily Journal *The Elmer Times* *Cumberland-Salem Guide* *South Jersey Times*

   The New Town Press Other _____

5. An advertisement in a magazine? Please circle which one:

   Suburban Family Magazine *Art of Living Well* *Clipper Magazine* Other _____

6. An advertisement in the phone book?

   Bridgeton/Millville Salem County Cumberland County Superpages

   Other _____

7. A placemat advertisement?

   Swedesboro Diner Harrison House Diner Woodstown Diner

8. Our Website www.drwarmuthskincarecenter.com _____

9. Our Facebook: www.facebook.com/drwarmuth _____

10. Our Twitter: www.twitter.com/dringridwarmuth _____