Reviewed by: M.A./R.N. _____

Patient Name: _____ Dr. _____

Date of Birth: _____/_____/_____ Date _____

Referred By _____

Have you been to our offices in the past 36 months? Yes / No, Approximate date of visit : _____

Allergies to medications _____ Other Allergies _____

Medications with/without prescriptions _____

_____

_____

Do you take any blood thinners? Circle: Aspirin Plavix Coumadin Aggrenox Eliquis Xarelto Pradaxa

Women: Are you Pregnant or Planning to become Pregnant? Y / N Nursing? Y / N

Date of last menstrual period _____ Menopause? _____

Reason for visit: (growth) (rash) • Itchy? Yes / No, • Bleeding? Yes / No, • Duration _____

Explain _____

_____

_____

_____

If rash, then list all prior prescriptions (by patient or doctor recommended). Also, list all soaps, lotions, creams you apply to your skin _____

_____

Have you had much sun exposure during your lifetime? Yes/No,

Do you use sunscreen with SPF 30 or higher? Yes/No

Current or Past problems (If checked) please explain below)

- ☐ **FLU VACCINE** (This Season) Yes__ No__
- ☐ Pacemaker / Defibrillator
- ☐ Blood / Bleeding Disorder
- ☐ HIV / AIDS
- ☐ Hepatitis B or C
- ☐ Heart Surgery
- ☐ Leaky Heart Valves
- ☐ Heart Attacks
- ☐ Irregular Heartbeat
- ☐ High blood pressure
- ☐ Headaches / Seizures / Migraines
- ☐ Eyes
- ☐ Ears / Nose / Throat
- ☐ Diabetes
- ☐ Stomach / Bowel / Liver problems
- ☐ Kidneys
- ☐ Arthritis / muscles / joints
- ☐ Skin Cancer: body location _____
- ☐ Skin rashes (type) _____
- ☐ Organ Transplant
- ☐ Lungs
- ☐ Psychological disorders
- ☐ Kidney problems
- ☐ Cancer (not skin)
- ☐ Thyroid
- ☐ Allergic / immunologic
- ☐ Other symptoms _____

Personal history of skin cancer? Yes / No: If Yes, which type? _____

Family History: any skin cancers, rashes etc.? _____

Social: alcohol? _____ Drink/day _____ Tobacco? _____ Occupation _____

Patient Signature _____

You are responsible to inform the doctor of any changes to this document

MARGARET S. RAVITS, M.D. AND ASSOCIATES

Welcome to the Office of Dr. Margaret S. Ravits and Associates DATE ___ /___ /___

Thank you for choosing our practice .

In order to serve you properly we will need the following information. All information will be strictly confidential ***(Please print)***

PERSONAL INFORMATION

NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET APT.NO CITY STATE ZIP

HOME PHONE (_____) _____ CELL PHONE _____ MARITAL STATUS (S / M / W /D / SP)

DATE OF BIRTH _____ / _____ / _____ AGE _____ SEX M/F _____ SOCIAL SECURITY _____ / _____ / _____

EMAIL ADDRESS _____

EMERGENCY CONTACT PERSON _____ PHONE (_____) _____

REFERRED BY _____ MEDICAL DOCTOR _____

ADDRESS _____ PHONE (_____) _____
STREET CITY STATE ZIP

EMPLOYMENT INFO

YOUR EMPLOYER _____

EMPLOYER ADDRESS _____
STREET CITY STATE ZIP

PHONE (_____) _____ OCCUPATION _____

INSURANCE INFORMATION

PRIMARY COVERAGE _____ IDENTIFICATION # _____
INCL. PREFIX / SUFFIX

SUBSCRIBER NAME _____ EFFECTIVE DATE _____ / _____ / _____

DATE OF BIRTH _____ / _____ / _____ RELATIONSHIP _____ SS # _____ / _____ / _____
REQUIRED

SECONDARY COVERAGE _____ IDENTIFICATION # _____
INCL. PREFIX / SUFFIX

SUBSCRIBER NAME _____ EFFECTIVE DATE _____ / _____ / _____

DATE OF BIRTH _____ / _____ / _____ RELATIONSHIP _____ SS # _____ / _____ / _____

TERTIARY COVERAGE _____ IDENTIFICATION # _____
INCL. PREFIX / SUFFIX

SUBSCRIBER NAME _____ EFFECTIVE DATE _____ / _____ / _____

DATE OF BIRTH _____ / _____ / _____ RELATIONSHIP _____ SS # _____ / _____ / _____

I hereby acknowledge receipt of Dr. Margaret S. Ravits and Associates Notice of Privacy Practices.

SIGNATURE _____ (Patient, Parent or Guardian) Date: _____ / _____ / _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request payment of authorized Medicare/other insurance company benefits be made to Dr. Margaret S. Ravits.
I authorize the release of medical records to the referring and primary care physicians and to my insurance company.

SIGNATURE _____ (Patient, Parent or Guardian) Date _____ / _____ / _____

I understand that I am financially responsible for all charges and copayment whether or not paid by insurance.

SIGNATURE _____ (Patient, Parent or Guardian) Date _____ / _____ / _____

NOTE: PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE COURSE OF YOUR TREATMENT.