

WELCOME TO HEIGHTS DERMATOLOGY & LASER, PLEASE TELL US ABOUT YOURSELF

PATIENT INFORMATION				
Last Name:				
First Name:		M.I.	Home Phone #:	
Street Address:		Apt.#	Work Phone #: Ext:	
Street Address2:			Date of Birth:	
Zip Code:			Social Sec. #:	
City:	State:	Sex (M/F):	Marital Status: (S)ingle (M)arried (O)ther	
Employed: (E)mployed (F)ull-time student (P)art-time student			Employer/School Name:	

REFERRING DOCTOR INFORMATION				
Last Name:		City:	State:	Zip:
First Name:		M.I.	Phone #:	
Address::				

PRIMARY INSURANCE INFORMATION				
Insurance Plan Name:			Group Name or Number:	
Attention:			Policy Effective Dates: From: To:	
Street Address:			Insurance ID#:	
City:	State:	Zip:	Copay:	
Phone Number:			Your relationship to the insured person Self Husband Wife Child Other	

PRIMARY INSURED PARTY INFORMATION-IF SAME AS ABOVE WRITE 'SAME'					
Last Name or Company:			Address:		
First Name:		M.I.	City:	State:	Zip:
Sex: (M)ale (F)emale			Insured Party ID#:	Phone #:	
Date-of-Birth:			Insured's Employer:		

SECONDARY INSURANCE INFORMATION				
Insurance Plan Name:			Group Name or Number:	
Attention:			Policy Effective Dates: From: To:	
Street Address:			Insurance ID#:	
City:	State:	Zip:	Copay:	
Phone Number:			Your relationship to the insured person Self Husband Wife Child Other	

SECONDARY INSURED PARTY INFORMATION-IF SAME AS ABOVE WRITE 'SAME'					
Last Name or Company:			Address:		
First Name:		M.I.	City:	State:	Zip:
Sex: (M)ale (F)emale			Insured Party ID#:	Phone #:	
Date-of-Birth:			Insured's Employer:		

PATIENT'S NAME (LAST, FIRST): _____ ACCOUNT# _____

DO YOU HAVE HISTORY OF:	YES	NO	FAMILY	DO YOU HAVE HISTORY OF:	YES	NO	FAMILY
ASTHMA				HAY FEVER			
HEART PROBLEMS				BLEEDING PROBLEMS			
EYE TROUBLE				DIABETES			
HYPERTENSION				STOMACH ULCERS			
TUBERCULOSIS				HEPATITIS			
TENDENCY TO SCAR TISSUE				KIDNEY DISEASE			
HISTORY OF SKIN CANCER				PACEMAKER			
OTHER ILLNESS							

IF THE PATIENT IS A CHILD: _____ PARENTS LAST NAME: _____ PARENTS FIRST NAME: _____

IF YOU HAVE ANSWERED 'YES' TO ANY OF THESE QUESTIONS, PLEASE DESCRIBE IN DETAIL: _____

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? _____ WHEN? _____

IS IT POSSIBLE THAT YOU ARE PREGNANT? _____ ARE YOU BREAST FEEDING ? _____

WHAT MEDICATIONS ARE PRESENTLY TAKING? _____

PLEASE LIST ALL ALLERGIES (MEDICATION OR OTHERWISE): _____

REASONS FOR BEING SEEN TODAY: _____

FOR MEDICARE PATIENTS:

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR. MARC AVRAM.

SIGNATURE: _____ DATE: _____

ALL OTHER PATIENTS:

I HEREBY GIVE PERMISSION TO BILL MY INSURANCE COMPANY. I REALIZE I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. I UNDERSTAND MY INSURANCE MAY NOT PAY FOR COSMETIC AND/OR OTHER PROCEDURES, THEREFORE I AM RESPONSIBLE FOR PAYMENT IN FULL.

SIGNATURE: _____ DATE: _____