Broward Dermatology
Medical - Cosmetic - Surgery

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(954) 362-4106 / BrowardDerm@Gmail.com
www.BrwDerm.com

PATIENT INFORMATION

Name: _____ Date of Birth ____/____/_____
Gender: [M] / [F]
Mailing Address_____
Home/Cell Phone ( ) _____ Secondary Phone ( ) _____
Social Security # _____-_____-_____ Email: _____

Person Responsible for the Bill/Insurance Holder (If Different From Patient)

Name: _____ Date of Birth ____/____/_____
Mailing Address_____
Home/Cell Phone ( ) _____ Secondary Phone ( ) _____
Social Security # _____-_____-_____ Email: _____

Emergency Contact Person: _____ Phone: _____

How did you hear about us? _____

PHARMACY Name/Phone Number (for e-prescribing): _____

Primary Care Physician: _____ Phone: _____

Do you have any of the following conditions? [ ] N/A

[ ] Heart Disease	[ ] Lung Disease	[ ] Hepatitis	[ ] Skin Cancer
[ ] Diabetes	[ ] High Blood Pressure	[ ] Blood Disorder	[ ] Other Cancer: _____
[ ] Hives	[ ] Kidney Disease	[ ] Bowel Disease	

[ ] Other: _____
[ ] **Check here if you are pregnant or trying to become pregnant.**

Please list any FAMILY history of skin diseases: _____
Allergies: _____
Current Medications: _____
Occupation: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payments of medical benefits to Broward Dermatology, LLC. I have been given a chance to read over the "Office Privacy Policy" (copies are available in the waiting room, or please ask for a copy).

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