Welcome to Greco Dermatology!

NOTE: If you have an HMO plan, you are responsible for obtaining an Authorization from your primary care physician prior toyour visit or we may have to reschedule your appointment.

Patient Information					
Patient Name: *(First Middle Last)*			**Date of Birth:***(mm/dd/yy)*		
Do you drink alcohol?	❑Yes ❑No	**Do you smoke Cigarettes/Cigars**?		**Do you use illicit drugs**?	❑Yes ❑No
If yes, how many times in the last year have you had 5 or more drinks in a day (male) or 4or more drinks in a day (female)?		❑Never smoked ❑Yes, ________________________cig/ day ❑I quit,_____❑days ❑mths ❑yrs ago Other Type of Tobacco: ___________		**If yes,** what type and how often?	

Reason for today's visit: ____

Are there any changes to your health insurance since your last visit: ❑Yes ❑No: if yes, list below

____

Are there any changes to your medical history since your last visit: ❑Yes ❑No; If yes list below

____

Are you taking any new medications since your last visit: ❑Yes ❑No

____

Current Influenza Immunization? ❑Yes ❑No

If no, why not? ______________________________

Vaccinated for Pneumonia? ❑ Yes ❑No

Do you wear sunscreen? ❑ Yes ❑No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions? ❑Yes ❑No

If yes, who?______________________________Phone Number:______________________________________

Do you have a living will? ❑Yes ❑No

By signing below, I authorize Greco Dermatology to import my medication history from my Pharmacy via SureScripts unlessthe following box is checked. ❑ If this box is checked, I do not authorize my medication history to be imported.

Allowing us to retrieve your medication history will ensure we have all pertinent information to confirm the information you provided above.

Patient Signature/POA/Guardian:____________________**Name (if not patient):**____________________**Date:** ____________

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