❑ 2620 S. Seacrest Blvd.
Boynton Beach, FL 33435
561-737-4888

❑ 24 S.E. 6th Street
Boca Raton, FL 33432
561-409-4375

Patient Ms. / Mrs. / Mr. ______________________________

Local Address ______________________________

______________________________ Local Phone # (   ) ______________
city   state   zip

Northern Address ______________________________

______________________________ Northern Phone # (   ) ______________
city   state   zip

Cell Phone # (   ) ______________ Email Address ______________ Preferred Language ______________

Race - White _____ Black _____ Native American _____ Asian _____ Other _____

Age _____ Date of Birth ______________ Ethnicity - Hispanic _______ Non Hispanic _________ Unknown _______

Name of Spouse (or if minor, responsible parent) ______________________________

Patient's Employer ______________________ Occupation ______________________

Address of Employment ______________________ Phone # (   ) ______________

Spouse's or Parent's Employer ______________________________

Address of Employment ______________________ Phone # (   ) ______________

Referred by ______________ Primary Care Physician ______________ Phone # (   ) ______________

Nearest relative not living with you ______________________ Phone # ______________

Who to contact in case of emergency ______________________ Phone # (   ) ______________

Patient Social Security Number ______________ Driver's License Number ______________ State ____

Medicare Number ______________________ Private or Supplemental Insurance ______________

Insured: ________ Patient ________ Spouse ________ Parent Insured's Date of Birth ______________

Contract # ______________________________ Group # ______________

I will be paying today by: Cash ____________ Check ____________ Credit Card ____________

Do we have permission to: (Check all that apply)

❑ Leave a message at your place of employment? ❑ Leave a message on your answering machine at home?

❑ Discuss your medical condition with a member of your household? If yes, whom ______________

❑ Email You? ❑ Text You?

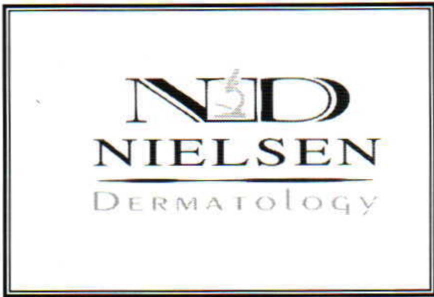
I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. All court fees, attorneys fees or other fees necessary to collect this account are payable by me. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

______________________________ Date ______________
Signature

______________________________ Date ______________
Parent (if minor)

WE WILL ACCEPT ASSIGNMENT WITH MEDICARE ON SERVICES RENDERED TO MEDICARE PATIENTS. ALL MEDICARE PATIENTS WILL BE RESPONSIBLE AT THE TIME OF VISIT FOR THEIR 20% AND ANY PART OF THEIR DEDUCTIBLE THAT HAS NOT BEEN MET.

Updated By: ______________________________
Date & Initial



Patient Name: ____

(Please **check** yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Itching		
Immunosuppression		

□**NONE OF THE ABOVE**

Other Symptoms: ______________________________________

ALERTS: (please **circle** all that apply)

Allergy to Adhesive or Band-Aid's
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant

□**NONE OF THE ABOVE**

Patient Name: ____

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
- Skin Cancer:
  - □Basal Cell
  - □Squamous Cell
  - □Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Rosacea

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 relative(s)? ____

Medications: (Please enter all current prescribed **oral** and **topical** medications)

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

□NO MEDICATIONS

Allergies: (Please enter all allergies)

______________________ ______________________
______________________ ______________________
______________________ ______________________

□NO KNOWN ALLERGIES

Social History: (Please circle all that apply)

Cigarette/Cigar Smoking:

- Currently Smokes
- Has smoked in the past
- Never smoked
- Former Smoker

Alcohol Use:

- EtOH- None
- EtOH- less than 1 drink per day
- EtOH -1-2 drinks per day
- EtOH -3 or more drinks per

Other ____

Patient Name: ____

Past Medical History: (please **circle** all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow
Breast Cancer
Colon Cancer
COPD
Coronary Artery

Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol

Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Problems:
 *Hypo
 *Hyper

□**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
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left)
Joint Replacement within last 2 years

Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer
Stents

□**NONE**

Other ____

Patient Name: ____

Family Medical History: **Please indicate disease and WHICH first degree relative. (mother, father and siblings)**

____
____
____

Discuss you medical condition with a member of your household? If yes, whom

____

□**NO FAMILY HISTORY**

Preferred Language: ______________________

Race: ___________________ **Ethnic Group:** ______________________

pharmacy:

Preferred Pharmacy Name: ____________________

Pharmacy Phone#: __________________________

Pharmacy Address: __________________________

Pharmacy City or Zip code: ____________________

THANK YOU!
Dr. Nielsen
&
Staff