Helendale
Dermatology&MedicalSpa

S _____
E _____
M_____

500 Helendale Road, Suite 100
Rochester, NY 14609
Phone: 585-266-5420 Fax: 585-266-5423

Please Complete and Return:

Patient: **Date of Birth:** **Age:** **Sex:**

Address: **City/State/ZIP**

Patient E-mail **Height:** **Weight:**

Phone Number: **Business/Cell Phone:**

☐**Single** ☐**Married** ☐**Other:** **Spouse's Name:**

If Minor, Person Responsible for Bills:

Billing Address (if different from above)

Health Insurance: **Contract #**

Name of Person Who Carries Health Plan: **Date of Birth:**

Place of Employment:

Pharmacy Name: **Phone #:**

Referred by: ☐**Friend** ☐**Relative** ☐**Physician** ☐**Advertisement** **Name:**

Primary Care Physician:

Relative and Friends Seen Here (list names):

Signature (please sign): **Date:**

Medical Problems/Conditions That You Have:

1. **3.** **5.**

2. **4.** **6.**

Diseases That Run In Your Family:

1. **3.** **5.**

2. **4.** **6.**

Type of Work You Do:

Is Your Skin Problem Work Related:

Current Medications You Take:

1. **3.** **5.**

2. **4.** **6.**

Drug Allergies:

1. **3.** **5.**

2. **4.** **6.**

Recent Hospitalizations and Surgeries:

	Year	Problem	Hospital	Physician
1.				
2.				