Steven E. Gammer, M.D., Inc.

Dermatology and Dermatologic Surgery
Diplomate American Board of Dermatology

Thank you for choosing our office to provide your dermatology care. We hope to make our office procedures as easy and convenient for you as possible by providing this information.

Included with this letter is our new patient information sheet and two questionnaires. Please fill these out and bring them with you the day of your appointment. If you have insurance, please bring your insurance card or cards with you. If not, we require payment when services are rendered. Please be prepared to pay deductibles, co-pays, and coinsurance portions at the time of service. The following forms of payment will be accepted: cash, check, MasterCard, Visa, American Express, or Discover Card. If you are presently taking any medication, you need to write down the name of your prescription and the dosage as Dr. Gammer will want this information as part of your medical history.

If you find it necessary to call our office to confirm, cancel or reschedule your appointment, please call (562) 431-8554.

Please arrive 15 minutes before your appointment time.

Dr. Gammer and Staff

500 Pacific Coast Highway, Suite 212 • Seal Beach, CA 90740 • (562) 431-8554

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PATIENT INFORMATION FORM

GETTING TO KNOW YOU

DID ANOTHER PHYSICIAN REFER YOU TO OUR OFFICE? ____ YES ____ NO	IF YES, REFERRING PHYSICIAN'S NAME:	IF NOT PHYSICIAN REFERRED, WHO MAY WE THANK FOR REFERRING YOU?

PATIENT'S FULL NAME (LAST, FIRST, M.I.):	PREFERRED TO BE CALLED BY:	SEX: ____ MALE ____ FEMALE	DATE OF BIRTH:	AGE:

PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP)

HOME PHONE:	CELL PHONE:	WORK PHONE:
WHICH NUMBER WOULD YOU PREFER TO BE CALLED AT: ____ HOME ____ CELL ____ WORK	SOCIAL SECURITY NO:	DRIVER'S LICENSE NO:

MARITAL STATUS (CIRCLE ONE) MARRIED DIVORCED SINGLE WIDOWED	SPOUSE:

RESPONSIBLE PARTY:	RESPONSIBLE PARTY'S RELATION TO PATIENT:	RESPONSIBLE PARTY'S ADDRESS AND PHONE:
PATIENT'S EMPLOYER:	PATIENT'S EMPLOYER'S ADDRESS AND PHONE:	OCCUPATION:

INSURANCE INFORMATION *****PLEASE PRESENT YOUR INSURANCE CARD OR CARDS FOR PHOTOCOPYING*****

PRIMARY INSURANCE:	POLICY NUMBER:	GROUP NUMBER:
POLICY HOLDER'S NAME:	RELATIONSHIP TO PATIENT:	DATE OF BIRTH:
SECONDARY INSURANCE:	POLICY NUMBER:	GROUP NUMBER:
POLICY HOLDER'S NAME:	RELATIONSHIP TO PATIENT:	DATE OF BIRTH:

EMERGENCY CONTACT INFORMAITON

PERSON TO CONTACT FOR EMERGENCY:	HOME PHONE: CELL PHONE:	ADDRESS, CITY, STATE, ZIP:
CLOSEST RELATIVE NOT LIVING WITH YOU:	HOME PHONE: CELL PHONE:	ADDRESS, CITY, STATE, ZIP:

PATIENT SIGNATURE: ____ **DATE:**___________________

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DATE ____________________

PATIENT: ________________________________

Please fill in those spaces that apply to you or circle the words that apply.

1. My present problem began, date ______________________________.
2. My present problem began on my (part of body): ______________________________
3. Past skin problems ______________________________
4. Do you have any allergies to medication? List: ______________________________
5. Have you had hay fever, asthma, eczema, wool allergy, hepatitis ______________________________
6. Have any of your relatives had these allergies ______________________________

Please answer by circling YES or NO and circle the words that apply.

7.	**YES**	**NO**	**FEMALE ONLY** Are you **PREGNANT?** Last menstrual period ______________________________
8.	YES	NO	Do you take birth control pills or hormone pills?
9.	YES	NO	Are you now taking medications? List ______________________________
10.	YES	NO	Have you taken medicines in the last two months? List ______________________________
11.	YES	NO	Are you using medications on the skin?
12.	YES	NO	Do you use laxatives?
13.	YES	NO	Do you use Anacin, Bayer or other aspirin?
14.	YES	NO	Do you use Tylenol, Caladryl, antacids, mouthwash?
15.	YES	NO	Do you take Coumadin, Heparin, Warfarin or other blood thinners?
16.	YES	NO	Do you take pain pills, nerve pills, stomach pills?
17.	YES	NO	Do you use Ivory or Irish Spring soap? What other soap?
18.	YES	NO	Do you use Noxema, face cream, baby oil, oily cosmetics?
19.	YES	NO	Do you use antistatic strips in the dryer (like Bounce)?
20.	YES	NO	Have you used any home remedies on the skin?
21.	YES	NO	Do you have a tendency to bleed? or your relatives?
22.	YES	NO	Do you form bad or irregular scars (keloid)?
23.	YES	NO	Have you had a bad reaction to Novocaine or anesthetics?
24.	YES	NO	Do you have diabetes or heart disease?
25.	YES	NO	Are you equipped with a pacemaker?
26.	YES	NO	Please list any past medical problems (not mentioned above) ______________________________

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I, ____,
hereby state that my lab/test results may be given to any of the following:

(Please check all that apply, and list names/phone numbers as appropriate)

- ☐ **Answer machine at phone number** ________________________
- ☐ **Spouse** ________________________
- ☐ **Mother** ________________________
- ☐ **Father** ________________________
- ☐ **Sister(s)** ________________________
- ☐ **Brother(s)** ________________________
- ☐ **Son(s)** ________________________
- ☐ **Daughter(s)** ________________________
- ☐ **Care Giver** ________________________
- ☐ **Other** ________________________

- ☐ **NO ONE ELSE BUT PATIENT**

Patient Signature ________________________

Date ________________________

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