Renaissance Dermatology
5951 Renaissance Place, Suite C
Toledo, Ohio 43623
419-824-2288

Please bring insurance card , photo ID and list of any medications you may be taking to your appointment.

Appointment date/time _____

Please print legibly

Patient's Name: _____

Street Address: _____ City/State/Zip: _____

Home Phone _____ Social Security # _____

Cell Phone _____ Birthdate: _____ Age: _____

Work Phone _____ Sex: M F Marital Status: S M D W

Patient's employer: _____ Occupation: _____

Preferred contact: Home ( ) Work ( ) Cell ( )

Responsible Party: (For Minors Only)

Name: _____ Phone # _____

Address: _____

Primary Insurance: _____ Card Holder: _____ SSN: _____

Card Holder's DOB: _____ Card Holder's employer: _____ Work #: _____

Secondary Insurance _____ Card Holder: _____ SSN: _____

Secondary's DOB: _____ Secondary's employer: _____ Work # _____

Referring Physician: _____ Specialty _____

Street Address: _____ Phone # _____

I, _____ consent to medical treatment and the release of medical records as needed.

Please **initial** the following:

_____ **I was given a copy of the Notice of Privacy Practices.**

_____ **I was informed of my financial responsibility (no show, cancellation policy).**

1. Skin Problem(s): _____
   A. Location: _____
   B. Duration: _____
   C. (Circle) Itch, burn, pain, bleed, etc. _____
   D. Any treatment: _____
2. List all your medications: _____

_____

3. Pharmacy Name: _____ Pharmacy Number: _____

4. List all your allergies (meds, others): _____

5. Review of systems: (Circle) Fever, night sweats, chills, fatigue, leg swelling, chest pain, breathing problems, urination problems, nausea, vomiting, bowel movement problems, heart palpitations, joint pain, eye problems, heat/cold/sun intolerance.

6. Check any history of the following:

__ A. Skin rash or cancer: _____

__ B. Blood pressure/heart problems: _____

__ C. Diabetes/thyroid problems: _____

__ D. Bleeding/clotting problems: _____

__ E. Liver/kidney/stomach problems: _____

__ F. Breathing/allergy/hay fever problems: _____

__ G. Neurologic of psychiatric problems (specify) _____

__ H. Arthritis/lupus/autoimmune diseases: _____

__ I. Eye problems: _____

__ J. HIV/risk factors: _____

__ K. Substance use (Alcohol/tobacco/drugs): _____

__ L. Surgeries/hospitalizations: _____

__ M. Other Health Problems: _____

Comments/further history/information:

_____

_____

_____

_____

_____

_____

FOR WOMEN (Please circle below)

1. Do you get menstrual cycle? Yes/No, Are they irregular? Yes/No
2. Are you pregnant? Yes/No, Nursing? Yes/No, Taking birth control? Yes/No
3. Do you have acne, dandruff, hair loss (scalp), or excessive hair growth (face, body)? Yes/No

_____

Office Use Only: (please do not write below line)

I have reviewed this intake questionnaire with the patient at the time of visit

_____ Date: _____

Mounir Boutros, M.D., F.A.A.D./Nina Rettig, PA /Megan Peck, PA /Amy Bergan, PA