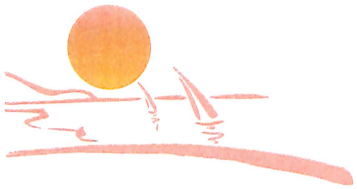

LYNN DIMINO M.D. BAYVIEW DERMATOLOGY AND LASER MEDICAL CENTER 360 SAN MIGUEL DR. #603 NEWPORT BEACH, CA 92660

In order to serve you properly, please provide the following information. Print clearly and leave no blanks.

Today's Date: _____/_____/_____

(Insurance Card & Valid Proof of Identification is required)

Patient Name _____ DOB _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

E-mail address _____

Permission to receive email notifications YES / NO

Home Phone _____ Cell Phone _____

Best number to reach you? Home / Cell

If patient is a minor, who maty authorize treatment? _____

Relationship _____

Employer Name _____ Phone_____

Address _____City _____ State _____ Zip _____

Emergency Contact _____ _____Phone _____ Relationship _____

Primary Care Physician _____ *Phone* _____

Do you have Insurance? Yes /No How did you hear about our office?

_____

INSURANCE – (Insurance companies require the information below for billing purposes.)

Primary Insurance _____Policy Insured Name _____ DOB _____

Policy ID _____Group Number _____ Relationship to Patient _____

Secondary Insurance _____Policy Insured Name _____ DOB _____

Policy ID _____ Group Number _____ Relationship to Patient _____

DO WE HAVE PERMISSION TO: Leave a message on your voicemail or answering machine? YES/NO

I authorize Lynn Dimino M.D. and /or Staff involved with my care to discuss medical and/or billing information with the following individuals.

_____ _____ _____

Name Relationship Phone

LYNN DIMINO M.D. / BAYVIEW DERMATOLOGY AND LASER MEDICAL CENTER 360 SAN MIGUEL DR. #603 NEWPORT BEACH, CA 92660*

Patient Health History Form

Please fill our ALL of the following requested information

Have you had any of the following skin conditions? If any are checked, please note when

__ Acne
__ Hay Fever/Allergies
__ Actinic Keratosis
__ Asthma
__ Basal Cell Skin Cancer
__ Blistering Sunburns
__ Dry Skin
__ Eczema
__ Flaking or Itchy Scalp
__ Melanoma
__ Poison Ivy
__ Precancerous Moles
__ Psoriasis
__ Squamous Cell Skin Cancer
__ NONE

__ Other, Please Explain: _____

Do your 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)? _____

Social History (Please check All that apply)

Smoking Status:

__ Daily Smoker
__ Never Smoked
__ Quit, Former Smoker
__ Smokes less than daily

When did you start smoking? _____
When did you stop smoking? _____
Number of packs per day? _____
Total years smoking? _____

Alcohol:

__ Never
__ One to two drinks per day
__ Three or more drinks per day

Caffeine:

__ Never
__ Once a Day
__ Several times a day

Driving Status:

__ Drives in daytime
__ Drives at night
__ Both

How often do you exercise?
__ Once a day
__ A few times a day
__ Never
__ Other

Have you had a Flu Shot this Season? YES __ NO __

For patients over the age of 65, Have you had a pneumonia Shot this Year? YES __ NO __
Do you have a Health Proxy in the event that you are unable to make your own medical decisions? YES __ NO __

If yes, Designee Name: _____

Patient Name: _____ DOB: _____

LYNN DIMINO M.D. / BAYVIEW DERMATOLOGY AND LASER MEDICAL CENTER 360 SAN MIGUEL DR. #603 NEWPORT BEACH, CA 92660*

Patient Health History Form

Please check off any of the following medical conditions that you currently have OR have had (If any are checked, please note when)

__ Anxiety
__ Arthritis
__ Asthma
__ Atrial Fibrillation (Irregular Heartbeat)
__ Bone Marrow Transplantation
__ BPH (Benign Prostatic Hyperplasia)
__ Breast Cancer
__ Colon Cancer
__ COPD
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ End Stage Renal Disease
__ GERD
__ Hearing Loss
__ Arthritis
__ Hypertension
__ HIV/AIDS
__ Hypercholesterolemia
__ Hyperthyroidism
__ Leukemia
__ Lung Cancer
__ Lymphoma
__ Prostate Cancer
__ Radiation Treatment
__ Seizures
__ Stroke
__ NONE
__ Other, please explain: _____

_____

Have you had any surgeries on the following organs?

__ Appendix (Appendectomy)
__ Bladder (Cystectomy)
__ Breast: Breast Biopsy
__ Breast: Lumpectomy (Both Breast)
__ Breast: Lumpectomy (Right Breast)
__ Breast: Lumpectomy (Left Breast)
__ Breast: Mastectomy (Both Breast)
__ Breast: Mastectomy (Right Breast)
__ Breast: Mastectomy (Left Breast)
__ Colon: (Colectomy) Colon Cancer Resection
__ Colon: (Colectomy) Diverticulitis
__ Colon: (Colectomy) Inflammatory Bowel Disease
__ Gallbladder (Cholecystectomy)
__ Heart: Biological Valve Replacement
__ Heart: Coronary Artery Bypass Surgery
__ Heart: Heart Mechanical Valve Replacement
__ Heart: PTCAP
__ Joint Replacement: Hip (Both)
__ Joint Replacement: Hip (Left)
__ Joint Replacement: Knee (Both)
__ Joint Replacement: Knee (Left)
__ Joint Replacement: Knee (Right)
__ Kidney (Nephrectomy)
__ Liver: Hepatectomy
__ Liver: Liver Transplant
__ Liver: Shunt
__ Ovaries: (Oophorectomy) Endometriosis
__ Ovaries: (Oophorectomy) Ovarian Cancer
__ Ovaries: (Oophorectomy) Ovarian Cyst
__ Ovaries: Tubal Ligation
__ Pancreas (Pancreatectomy)
__ Prostate: (Prostatectomy)
__ Prostate: Prostate Biopsy
__ Prostate: TURP
__ Skin: Basal Cell Carcinoma
__ Skin: Biopsy
__ Skin: Melanoma
__ Skin: Squamous Cell Carcinoma
__ Spleens (Splenectomy)
__ Testicles (Orchiectomy)
__ Uterus: (Hysterectomy)
__ Uterus: Fibroids
__ Uterus: Uterine Cancer
__ Uterus: Uterine Cancer
__ Uterus: Cervical Cancer
__ NONE

__Other, Please Explain: _____

LYNN DIMINO M.D. / BAYVIEW DERMATOLOGY AND LASER MEDICAL CENTER 360 SAN MIGUEL DR. #603 NEWPORT BEACH, CA 92660*

Patient Health History Form

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy City: _____

Please list any current medications/vitamins and allergies. If you have medication/vitamin list, please provide it to the front desk so we can attach it to your chart.

PLEASE PROVIDE ALL INFORMATION

Allergies:

__ NONE
__ Other, Please List: _____

Medications/Vitamins:

__ NONE

MEDICATION/VITAMIN	ROUTE (ORAL OR INJECTION)	DOSE/STRENGTH	FREQUENCY (DAILY AM/PM)