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**Welcome to Our Office**

Thank you for choosing our office. In order to serve you properly, <b>PLEASE PRINT</b> the following information.			
Name:			Chart #
Address:		City/State/Zip:	
SSN:	Birthdate:	Marital Status:	Gender:
Home Ph:	Work Ph:	Other Ph:	Email:
Occupation:			
Emergency Contact Name:			
Relationship:			
ER Contact Home Ph:		ER Contact Work Ph:	
How did you hear about us?			
Referring Doctor Name and Phone Number:			
Person financially responsible for treatment if not Self:			
Address of person financially responsible:			
Phone number of person financially responsible:			
Accepted forms of payment: <b>CASH VISA/MASTERCARD ATM/DEBIT CARD</b>			
Primary Ins Subscriber Name & Date of Birth:		Primary Ins. Subscriber ID#:	
Secondary Ins Subscriber Name & Date of Birth:		Secondary Ins Subscriber ID#:	
Which method do you prefer us to contact you?		<input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Other _____	
May we contact you via EMAIL to update you on any new dermatological/cosmetic services? YES <input type="checkbox"/> NO <input type="checkbox"/>		Email Address:	
The doctor prefers to perform a New Patient Thorough Skin Exam with your permission <input type="checkbox"/> I Accept <input type="checkbox"/> I Decline			
<b>Appointment Policy:</b> I have read and I agree to the terms of the Appointment Policy! YES <input type="checkbox"/>			
I also acknowledge that I have received a copy. <b>Signature:</b>			
I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.			
<b>Patient, Parent or Guardian Signature:</b>			Date:

**Health Information**  
**(Please Print Legibly & Fill In Correct Fields)**

Confidential Record: The information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Lbs.

Current Physician(s): \_\_\_\_\_

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Acne	No	Yes	Herpes: Type _____	No	Yes	Rheumatoid Disease	No	Yes
Aids / HIV	No	Yes	Implant: Type _____	No	Yes	Sinus Problems / Infections	No	Yes
Arthritis	No	Yes	Lupus	No	Yes	Skin Cancer	No	Yes
Artificial Joint	No	Yes	Melanoma	No	Yes	Sun Sensitivity	No	Yes
Diabetics	No	Yes	Mitral Valve Prolapse	No	Yes	Transfusions	No	Yes
Eczema	No	Yes	Pace Maker	No	Yes	Ulcers	No	Yes
Heart Trouble	No	Yes	Pre-Cancerous Lesions	No	Yes	Vitiligo	No	Yes
Heart Valve	No	Yes	Psoriasis	No	Yes	Other		
Hepatitis	No	Yes	Rash / Allergic skin reaction	No	Yes			

Do you smoke? No Yes If yes, how much? \_\_\_\_\_ Pack(s)/day How long? \_\_\_\_\_ Years

Do you drink alcohol? No Yes If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_

Family History of Skin Cancer? No Yes If yes, who? \_\_\_\_\_

Do you use recreational drugs? No Yes If yes, describe: \_\_\_\_\_

Do you have bleeding or bruising problems? No Yes If yes, describe: \_\_\_\_\_

Do you have problems with scarring? No Yes If yes, describe: \_\_\_\_\_

Do you have any history of problems with anesthesia? No Yes If yes, describe: \_\_\_\_\_

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug allergies.

The above information is accurate and complete to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_