JOHN K. MALLEN, M.D.
32 Stiles Road, Suite 204
Salem, NH 03079
(603) 894-9898

Date:________________________

NAME:____ Sex: ___ Male ___Female

Address:____City____________________State______Zip_________

There are occasions when it is necessary to call a patient, to discuss any pertinent information. It may also be necessary to leave a message on an answering machine or with a person. Please leave a telephone number/numbers that we can call. Also, indicate if it's a home, work or cell phone number and sign below.

PHONE #1: _____________________________ *PHONE #2:* _______________________________

HOME CELL WORK (w/ext.) HOME CELL WORK (w/ext.)

*PATIENT SIGNATURE:*____

Birth Date:_______________ SS#:_______________________ Circle One: Single Married Divorced Widowed

Patient Employer Name & Address:____

Emergency Contact & Phone:____

Name of Primary Care Physician:_______________________________ Referring Physician/Individual___________________

Is your injury work related?_____________________ Auto related?___________________ Date of Injury:________________

INSURANCE INFORMATION

Insurance Co.__________________________________ Group #:__________________ Subscriber ID#:__________________

Policyholder's Name:________________________ DOB:___________ Relation to Patient:____________ SS#____________

Employer Name & Address:____

Do you have any additional insurance? ___Yes ___No If yes, complete the following:

Policyholder's Name:_________________________ DOB:________________ Relation to Patient:______________________

SS#:____________________ Insurance Co.________________________ Group #_______________ ID:_________________

SIGNED:____ DATE__________________________

I authorize the taking of photographs by John K. Mallen, M.D., and/or staff for documentation and record keeping purposes.

SIGNATURE:____ DATE__________________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers and insurance companies any information needed for this or related Medicare or insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits payable to John K. Mallen, M.D. I acknowledge that I am responsible for any balance not covered by my insurance company.

SIGNATURE:____ DATE__________________________

JOHN K. MALLEN, M.D.
PERSONAL MEDICAL HISTORY

Please check appropriate boxes:

	YES	NO		YES	NO
Have you ever had an eye injury?			Do you take anti-inflammatory medication?		
Do you wear glasses or contacts?			Do you have a personal history of skin cancer?		
Have you ever had a facial nerve injury?			Do you have a family history of skin cancer?		
Have you ever had impaired hearing?			Have you ever had cancer of any kind?		
Have you ever had a loss of smell?			Do you form unusually heavy scars?		
Have you ever had black out spells?			Have you ever tested positive to a skin test?		
Have you ever had seizures?			Have you ever had a skin disease?		
Have you ever had a chronic cough?			Have you ever had high blood pressure?		
Have you ever had asthma?			Have you ever had blood in stool or urine?		
Have you ever smoked?			Have you ever had a heart attack?		
Have you ever taken steroids/Cortisone?			Do you have Prolapsed Mitral Valve?		
Have you ever taken Fen/Phen or Redux?			Do you have numbness of hands or feet?		
Do you use alcohol?			Have you ever had a hand or arm injury?		
Do you take aspirin daily?			Are you diabetic?		
Do you use eye drops regularly?			Other *(please list)*		
Do you take arthritis medication?					
Have you ever had radiation therapy?					

If the following do not apply, please indicate by writing none or n/a:

List all allergies.	List all prescription medications. Also include all herbal,
	natural health food store, weight loss, and/or energy drugs taken.
List previous surgeries.	
List all pregnancies.	

REASON FOR VISITING OUR OFFICE TODAY:____

Answering the following questions is OPTIONAL. This information helps us to better serve our patients.

How did you hear about us? Referral by: ____ Physician ______ Patient ______ Friend

____ Yellow Pages Ad ________________________ *(which town and phone book)* ____Mailing to home ____ Attended seminar ______________ *(place)*

Are you interested in attending a free seminar? YES NO

Are you interested in obtaining more information on any of the following?

Cosmetic Surgical Procedures ______________________ Cosmetic Non-Surgical Procedures ______________________

Non-Surgical Skin Rejuvenation ______________________ Home skin care products __________________________

PATIENT'S NAME: ____**DATE:** ____________________________