Dr. Alan J. Liftin, MD
22 Old Short Hills Road, Suite 103
Livingston, NJ 07039

Today's date:_____ Office account #:_____

Patient Name:_____ Email Address: _____
Address:_____

Phone: Home ( )_____ Cell ( )_____ Date of Birth:_____

Age____ Sex: M F Social security #:_____ Single____ Married_____ Widow(er)_____

Insurance Plan: Primary_____ Secondary_____
Identification: Primary_____ Secondary_____
Group ID #: Primary_____ Secondary_____

Pharmacy : _____
Subscriber (if not patient): Name_____ SS #_____ DOB _____

Referred By (Include doctor's address)_____

Do you have a history of any allergies to medicines OR foods? If yes, please list: _____
_____

Do you have a past history of skin disease? If yes, please list: _____
_____

Are you currently taking any prescribed or over the counter medicines? If yes, please list: _____
_____

Is there a family history of malignant melanoma? If yes, in whom? _____

Do you have a prior medical history of: (Please circle)

DIABETES	**HEART DISEASE**	**HIGH BLOOD PRESSURE**
ARTHRITIS	**THYROID DISEASE**	**CANCER**
SKIN CANCER	**HEPATITIS**	**INFECTIOUS DISEASE**
PROSTHESES	**ABNORMAL WOUND HEALING**	**KELOIDS OR ABNORMAL SCARS**
LIVER DISEASE	**KIDNEY DISEASE**	**ARTIFICIAL HEART VALVE**

SURGERY_____

ANY OTHER MEDICAL PROBLEMS:_____

I authorize payment of medical benefits from my insurance carrier to Dr. Liftin; I authorize release of any medical or other information needed to process my insurance claim.

I realize that I am responsible for understanding my insurance policy coverage and that I am financially responsible for all charges whether or not they are covered by insurance.

I acknowledge receipt of ALAN J. LIFTIN's Notice of Privacy Practices.

Patient signature_____ Date: _____