Esta Kronberg M.D.

Patient Profile

Please Print

Date_____ Social Security # _____-_____-_____

Mr. or Ms. Last_____ First_____ MI_____

Spouse: Last_____ First_____ MI_____

Address_____City_____ State_____Zip_____

Phone: Hm_____ Wk_____ Cell_____ Spouse's Wk_____

DOB _____/_____/_____ Age_____ Dr.Lic. _____ Sex M / F ☐Married ☐Single ☐Divorced ☐Widowed

Employer _____ Occupation _____

Person Responsible for Account

Mr. or Ms. Last_____ First_____ MI_____

Address_____City_____ State_____Zip_____

Phone: Hm_____ Relationship_____ SS# _____-_____-_____ Dr. Lic. _____

Person to Contact in an Emergency

Mr. or Ms. Last_____ First_____ MI_____

Address_____City_____ State_____Zip_____

Phone: Hm_____ Relationship_____ Sex M / F

How did you find us? ☐Yellow Pages ☐Ad ☐TV ☐Referral Service ☐Radio ☐Internet

Dr. Referral (Name) _____ Patient (Name) _____

Reason for Visit Today_____ Other Medical Problems _____

Allergies to Medications or Foods _____ Current Medications _____

Medical History

Length of Present Problem_____ Location on Body_____ Present Treatment_____

Pacemaker Y / N Pregnant Y / N / Maybe Do You Take or Use: ☐Vitamins ☐Laxatives ☐Tanning Bed Sunbathe Y /N

Past Medical History:

☐Ulcer ☐Fainting ☐Diabetes ☐Epilepsy ☐High Blood Press. ☐Heart Disease ☐Hepatitis ☐Hay Fever ☐Seizures ☐Eczema ☐Hives ☐Lung Disease ☐Lupus ☐Herpes (Fever Blisters) ☐Arthritis ☐Phlebitis ☐Liver Disease ☐Kidney Problems ☐Blood Clots ☐Bleed Easily

Skin Diseases _____ Family History of Skin Diseases _____

Surgeries _____Smoke Y/N How much _____ Alcohol Y/N How often _____

Full payment is due at the time of service and you will be provided with a receipt that you can submit to your insurance company for reimbursement. Some cosmetic procedures require a deposit.

We accept cash, personal checks and all major credit cards.

Patient or Guarantor Signature _____

I authorize the release of any medical records requested by my insurance company.