Integrated Dermatology of Mission Viejo, APMC
26691 Plaza, Ste 230, Mission Viejo, CA 92691-6300

Tel 949-364-2904
Fax 949-364-2909

Medical Information

Name: ______________________________ **DOB:** ______________
Last, First Middle or Initial *mm/dd/yyyy*

Medical History: *Please list any existing illness*

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Surgical History: *Please list surgeries done especially joint*

______________ ______________ ______________
______________ ______________ ______________

Allergies: *Please list medication allergies and respective reactions*

Medication	Reaction	Medication	Reaction

Medication List:

Name	Dose	How often	Name	Dose	How often

Immunization History:

Have you had COVID-19 Vaccine? (Circle one) Yes No If so, how many doses? ______________

Pharmacy Information: *Please provide preferred pharmacy information*

Name: ______________________________ ID#: ______________

Address: ______________________________

City: ______________ State: ______________

Tel: ______________ Fax: ______________

By signing below, I acknowledge that I understand the risks and consent to minor office procedures and agree to the financial charges. This consent will remain effective from the signing date until a written notice to terminate this consent has been received.

Patient Signature ______________________________ Date ______________
or Guardian/Legal representative for patient *yyyy/mm/dd*