BANKI DERMATOLOGY & COSMETIC CENTER

Ali Banki, D.O. | Kristi Krikris, PA-C | Adrianna Pliszka, PA-C
2928 Main Street Suite 200 Glastonbury, CT 06033 | 860-659-2779

Please Fill in ALL information Prior to Your Visit:

Patient Name:
Last First MI
Date of Birth: Age: **Sex:** M / F

Patient Contact Info:
Address Zip City

Preferred Phone #:
Secondary#: Other # or Email:
May we leave a message? (Please circle one) Y / N

Marital Status: S M D W

Employer:

PCP: Phone# Address

Who Referred you:
Address
Phone

Minors (18 years old or younger):
Parents/ Guardian's Name:
Address Phone

Insurance Information:
Primary Insurance Carrier
Relationship to insured: (Please circle one) SELF | SPOUSE | CHILD
Name of Primary Insurance Holder: DOB

ID # Group# Issue Date
Employer

Secondary Insurance Carrier
Relationship to insured: (Please circle one) SELF | SPOUSE | CHILD
Name of Primary Insurance Holder: DOB

ID # Group# Issue Date
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Please fill out ALL Information Prior to Your Visit:

PAST MEDICAL HISTORY & INTAKE FORM (Please Circle all that applies)

Anxiety	Coronary Artery Disease	Leukemia
Arthritis	Depression	Lung Cancer
Asthma	Diabetes	Lymphoma
Bone Marrow Transplant	End Stage Renal Failure	Prostate Cancer
BPH	GERD	Radiation Treatment
Breast Cancer	Hearing Loss	Seizures
Colon Cancer	High Blood Pressure	Stroke
COPD	High Cholesterol	Thyroid Condition (Hyper/Hypo)

Other: _____

_____

_____

Past Surgical History: _____

_____

_____

Medications: (If you have a Medication list, please hand it to receptionist to scan in)

_____

_____

Pharmacy Information:

Name Address _____

Phone # _____

Please describe the reason for your visit:

_____

_____

List Any Drug Allergies: (If you have an allergy list, please hand it to Receptionist to scan in)

_____

_____

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Are you allergic to Latex? Y / N **Are you allergic to Lidocaine or Epinephrine?** Y / N
Do you drink alcohol? Y/N **Do You wear sunscreen**: Y/N If yes, What SPF? ___
Cigarette Smoking? (Please Circle) Never, Quit: Former, Smoker

Have you had any of the following?
Hepatitis: Y / N **Abnormal Heart Valve:** Y / N **Positive HIV:** Y / N **Artificial Joints:** Y / N
Atrial Fibrillation: Y / N **Pacemaker:** Y /N **Do you take aspirin or Coumadin?** Y / N
Did you have a flu vaccine this year? Y/N **Do you have an Advanced Care Plan?** Y/N
Did you receive your covid-19 vaccine? Y/N If yes, **did you also receive your Covid-19 booster**? Y/N

Anyone else we release your medical information to?

Print Name: _____ Relationship_____ Phone_____
(If you are or have a Power of Attorney: We will need your letter of proof for POA prior to being seen. You will also have to be accompanied by your assigned POA for your visits)

I hereby authorize treatment of the above patient. I acknowledge full responsibility for the payment of services rendered. I understand and agree that medical insurance is an arrangement between the insurance carrier and the patient. I also authorize Dr. Banki to release any medical information necessary to process the claim(s).

Signature:_____ Date:_____