

**PATIENT INFORMATION**  New Patient  Name Change  Address Change  Insurance Change

**THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:**

Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
*Last* *First* *M.I.*

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex:  Male  Female

**ADDRESS:**

Mailing Address \_\_\_\_\_  
*City* *State* *Zip*

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

**PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)**

Name \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
*Last* *First* *M.I.*

Address \_\_\_\_\_  
*City* *State* *Zip*

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**INSURANCE COVERAGE - PRIMARY:**

Insurance Co. Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Address of Claim Center: \_\_\_\_\_

*City* *State* *Zip Code*

Name of Policy Holder (Insured): \_\_\_\_\_

Insured Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Sex:  Male  Female

Policy #: \_\_\_\_\_ Group Name or #: \_\_\_\_\_

Policy Type:  HMO  PPO

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

If patient is child, check relationship:  Mother  Father  Other \_\_\_\_\_

**INSURANCE COVERAGE - SECONDARY:**

Insurance Co. Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Address of Claim Center: \_\_\_\_\_

*City* *State* *Zip Code*

Name of Policy Holder (Insured): \_\_\_\_\_

Insured Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Sex:  Male  Female

Policy #: \_\_\_\_\_ Group Name or #: \_\_\_\_\_

Policy Type:  HMO  PPO

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

If patient is child, check relationship:  Mother  Father  Other \_\_\_\_\_

Referred by: \_\_\_\_\_

**ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)**

**REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND  
SIGNATURE ON FILE**

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Other family members that are patients \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

In case of emergency, who should be notified? \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

YES  NO If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): ( \_\_\_\_\_ ) \_\_\_\_\_ Phone: # (evening): ( \_\_\_\_\_ ) \_\_\_\_\_

**May we leave personal medical information on your answering machine at home?**

YES  NO

Pharmacy: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PAYMENT POLICY:**

**HMO, PPO or other managed care patients:** You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

**Commercial Patients:** Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Dermatology Medical History

Patient: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  Yes  No If yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  Yes  No Any bad reaction:  Yes  No

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins and herbals

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
<b>Lungs:</b>			<b>Other Systemic:</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>	<b>YES</b>	<b>NO</b>	Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Artificial Joint</b>	<input type="checkbox"/>	<input type="checkbox"/>
List any other diseases or conditions: _____			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
List surgical procedures you have had in the last 6 months: _____			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

**Skin:** Have you ever had skin cancer?  YES  NO  
 Has anyone in your family had skin cancer?  YES  NO  
 Do you have a history of any specific skin diseases?  YES  NO If YES, \_\_\_\_\_  
 Do you have problems healing?  YES  NO  
 Do you develop keloids (scars) after surgery?  YES  NO  
 Do you bleed easily?  YES  NO  
 Do you develop skin rashes in reaction to  Medications  Food  Environment  Bandages  Topical Neosporin  
 Other \_\_\_\_\_

**Social History:**  
 Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day \_\_\_\_\_  
 Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_  
 Have you had or have you been exposed to HIV (AIDS)?  YES  NO

Please answer the following questions:  
 (Women) Are you pregnant?  YES  NO Due Date: \_\_\_/\_\_\_/\_\_\_  
 What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:  Patient  Medical Assistant  
 Signed Patient \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Reviewed by \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_