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: _____ Sex: ❑ Male ❑ Female SS#_____

ADDRESS:

Mailing Address _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ E-mail: _____

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

Name: _____Date of Birth: ____/____/____
Last *First* *M.I.*

INSURANCE COVERAGE

Insurance Co. Name:_____

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?_____ Phone ( )_____

Relationship to patient: _____

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 or cell phone? ❑ YES ❑ NO

May we e-mail personal medical information to you? ❑ YES ❑ NO

Preferred pharmacy for prescriptions: _____

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:

You will be responsible for paying your annual deductible, copayment and charges for any non-covered medical and cosmetic services at the time of service.

Responsibility of Payment Signature _____ Date ____/____/____

Dermatology Medical History

Patient: _____ Date of Birth:___/___/___ Today's Date: ____/___/___

Reason for today's visit: _____

Have you been previously diagnosed with any of the following:

- ☐ Anxiety /Depression
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Breast Cancer
- ☐ Coronary Artery Disease
- ☐ End Stage Renal Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Lymphoma
- ☐ Seizures
- ☐ Arthritis
- ☐ BPH (Enlarged Prostate)
- ☐ Colon Cancer
- ☐ Heart Valve Replacement
- ☐ GERD (Acid Reflux)
- ☐ Hypertension
- ☐ Leukemia
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Asthma
- ☐ Bone Marrow Transplant
- ☐ COPD
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ HIV/AIDS
- ☐ Lung Cancer
- ☐ Radiation Treatment
- ☐ Joint Replacement

List any other past or present diseases or conditions:_____

List any surgical procedures:_____

Have you had any of the following skin conditions:

- ☐ Acne
- ☐ Basal Cell Carcinoma
- ☐ Eczema
- ☐ Melanoma
- ☐ Psorasis
- ☐ Actinic Keratosis
- ☐ Blistering Sunburn
- ☐ Flaky or Itchy Scalp
- ☐ Poison Ivy
- ☐ Squamous Cell Carcinoma
- ☐ Asthma
- ☐ Dry Skin
- ☐ Hay Fever/Allergies
- ☐ Precancerous Moles
- ☐ Other

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 disease? ☐ Yes ☐ No
Do you develop keloid scars after surgery? ☐ Yes ☐ No
Do you bleed easily? ☐ Yes ☐ No
Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Ointment Antibiotic

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

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

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
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

(Women) Are you pregnant? ☐ Yes ☐ No Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by:

☐ Patient _____ ___/___/___ ___/___/___ _____
Signed by Patient Date Updated Init

☐ Med. Assist _____ ___/___/___ ___/___/___ _____
Reviewed By Date Updated Init