Center For Dermatology

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ DOB____/_____/____

Sex: □ M □ F Marital Status: □Single □Married □Divorced □Widowed SSN_____

Home Address _____

Apt or Unit #_____City_____State_____Zip_____

Phone: **H**ome _____**M**obile _____ **W**ork _____ Preferred: □**H** □ **M** □ **W**

Email Address _____

Employment Status: □ Employed□ Unemployed □ Student □ Retired Employer Name _____

Emergency Contact _____Relationship _____ Phone_____

Preferred Language _____ Race_____ Ethnicity_____

RESPONSIBLE PARTY INFORMATION, PARENT/LEGAL GUARDIAN (If patient is under 18yrs)

Last Name _____ First Name _____ DOB_____/_____/_____
Relationship to Patient _____ SSN _____
Home Address: _____City _____ State _____ Zip _____
Home Phone _____ Cell Phone_____ Work phone_____

INSURANCE INFORMATION

Primary Insurance Company _____ Subscriber Name_____
Subscriber SSN#/ID _____ DOB____/____/____ Relationship_____
Secondary Insurance Company _____ Subscriber Name _____
Subscriber SSN #/ID _____ DOB____ /___/_____ Relationship_____

REFERRAL INFORMATION

PCP Name /Practice Name_____Address/Phone_____
Referring Physician/ Practice Name_____Address/Phone_____
How did you hear about us? □ Physician □ Insurance □ Internet _____ □Print _____
□ Family _____ □ Friend _____

COMMUNICATION CONSENT

Your provided information may be used to contact you by telephone/text/mail/email for the purpose of appointment reminder, treatment, payment, and/ or health care operations. We may leave a detailed message on your preferred phone number regarding biopsy reports, test results and prescriptions. If you have any restrictions, please let us know on this line.

_____

I authorize Center for Dermatology, LLC to obtain/have access to my medication history. I acknowledge above information is accurate. I understand that I am to inform Center for Dermatology LLC, of any changes as soon as they occur.

Patient /Guardian Name _____ Date_____

Center For Dermatology

Medical History

Patient Last Name_____ **Patient First Name**_____ **DOB**_____

PHARMACY _____ Address_____ City_____ Phone:_____

Primary Physician: _____

Referred by : □ Primary Physician □ Specialist Physician: _____

REASON FOR VISIT: _____

ALLERGIES _____ Latex Allergy : □Yes □No _____

MEDICATIONS_____

_____

_____

MEDICAL HISTORY Please *check all that apply.*

□Arthritis	□Depression	□Hypertension	□Seizures
□Asthma	□Diabetes	□Hyperthyroidism	□Stroke
□*AFib/Irregular Heart Beat*	□End Stage Renal Failure	□Hypothyroidism	□Seasonal Allergies
□Bone Marrow Transplant	□GERD (Reflux)	□Leukemia/Lymphoma	□Treatment with gold
□Breast Cancer	□Hearing Loss	□Irregular Periods	□Accutane use in past.
□*Cold sores/Fever blisters*	□*Hepatitis*	□Lupus	When_____
□Colon Cancer	□*Herpes*	□Lung Cancer	
□COPD/Emphysema	□*HIV/AIDS*	□Radiation Treatment	□**NONE**

Do you have any **other medical conditions?** _____

List any **surgical procedure** you had in the past _____

REVIEW OF SYSTEMS *Please check all that apply.*

□Abdominal discomfort	□Joint pains	□*Allergy to Lidocaine*	□*Heart Murmur*
□Blood in urine	□Muscle weakness	□*Allergy to Antibiotic Ointment*	□*Latex Allergy*
□Bloody / Loose stools	□Nausea/Vomiting	□*Artificial Heart Valve*	□*Liver Problems*
□Blurry Vision	□Neurological symptoms	□*Artificial Joints*	□*MRSA*
□Dry Skin	□Recent Weight Loss	□*Blood Thinners*	□*Pacemaker*
□Fever	□Sore throat	□*Defibrillator*	□***NONE***
□Headache	□Sun sensitivity	□*Epinephrine Sensitivity*	□*Other*_____
□Itching			

FOR FEMALE PATIENTS

Are you Pregnant? □Yes □No Birth Control Method_____

Are you Planning Pregnancy? □Yes □No Tubal Ligation □Yes □No Hysterectomy □Yes □No

Are you Nursing/Breastfeeding? □Yes □No Menopause □Yes □No

All medicines, including topical creams, have varying concerns during pregnancy or while nursing an infant.

Center For Dermatology

Patient Last Name_____ **Patient First Name**_____

SKIN DISEASE HISTORY Please check all that apply.

□Acne
□Actinic Keratosis
□Basal Cell Carcinoma
□Blistering Sunburns
□Eczema
□Poison IVY
□Precancerous Moles
□Psoriasis
□Squamous Cell Carcinoma
□ **None**
□ **Other:** _____

SOCIAL HISTORY

Do you Smoke? □ Never □ Past □ Daily □Occasional
Do you drink Alcohol? □ Yes □ No If yes, how many drinks per day? _____

OCCUPATION _____

FAMILY HISTORY Please check all that apply		
		Which Relative?
Eczema	□ Yes □ No	
Asthma	□ Yes □ No	
Psoriasis	□ Yes □ No	
Basal Cell Carcinoma	□ Yes □ No	
Melanoma	□ Yes □ No	
Squamous Cell Carcinoma	□ Yes □ No	
Lupus	□ Yes □ No	
Genetic Disorder	□ Yes □ No	
Type:		

A Yearly full skin exam is recommended for early detection of skin cancers. Would you like to have a full skin exam?
□Yes, Today (If time permitting). □Yes, Next visit □ No, I decline.

I certify that the medical history provided is correct and complete to the best of my knowledge.

_____ _____
Patient Signature; and if minor, parent, or guardian signature Date

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Center for Dermatology to release my medical and /or billing information to the following individuals(s):

1. _____ Relation to Patient _____

2. _____ Relation to Patient _____

3. _____ Relation to Patient _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date: _____