SPECIALISTS IN DERMATOLOGY & COSMETIC MEDICINE

Patient Information Form

Name: _____ _____
(First) (Last)

Date of Birth: __ __ / __ __ / __ __ __ __ GENDER: M F Marital Status: _____

SSN #: __ __ __ - __ __ - __ __ __ __

Address: _____ Suite / Apt: _____

City: _____ State: __ __ Zip Code: __ __ __ __ __

Home Phone: (__ __ __) __ __ __ - __ __ __ __

Work Phone: (__ __ __) __ __ __ - __ __ __ __

Mobile Phone: (__ __ __) __ __ __ - __ __ __ __

E-Mail: _____

Preferred Contact Method (Circle one): HOME MOBILE WORK

Insurance Policy Holder:

Name: _____ _____ DOB: __ __ / __ __ / __ __ __ __
(First) (Last)

Relationship: _____

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Medical History Form

Patient Name: _____ **Date of Birth:** __/__/____

Reason for Visit and Location of Problem: _____

Past Medical History: (Check all that apply. If NONE, please check NONE)

__ Allergies (Seasonal)
__ Asthma
__ Bleeding Disorder (or bleeding issue)
__ Cancer: _____
__ Coronary Artery Bypass
__ Depression
__ Diabetes
__ Fever Blister
__ Heart Valve Replacement
__ High Blood Pressure
__ High Cholesterol
__ HIV/AIDS
__ Joint Replacement
__ Kidney Transplant
__ Liver Disease
__ Lumpectomy
__ Lupus/ Rheumatoid Arthritis
__ Mastectomy
__ Organ Transplant
__ Thyroid Disease
Hyper or Hypo (Circle one)
__ **NONE**

Do you have a history of Skin Cancer or Skin Disorders?
(Examples: acne, actinic keratosis, basal cell, eczema, melanoma, psoriasis, squamous cell)
Yes____ No ____ If yes, please indicate condition or disorder: _____

Family History of Melanoma? (circle one) **Yes** **Relation:** _____ **No**

Medications: _____
(Enter all current medications including non-prescription and birth control: if none mark N/A)

Allergies: _____
(Please enter all allergies including allergy to medications; if none mark N/A)

Review of Symptoms: (Check all that apply. If NONE, please check NONE)

__ Problems with bleeding
__ Problems with healing
__ Problems with scarring/keloids
__ Fever or Chills
__ Other: _____
__ Night Sweats
__ Unintentional weight loss
__ Joint Pain
__ **NONE**

Alerts: (Check all that apply. If NONE, please check NONE)

__ Allergy to Adhesive
__ Allergy to Lidocaine
__ Allergy to Topical Antibiotics
__ Artificial Heart Valve
__ Blood Thinners
__ MRSA
__ Pacemaker
__ Require antibiotics prior to surgical procedure
__ Rapid heartbeat with Epinephrine
__ Defibrillator
__ Are you pregnant or currently trying to get pregnant? Notify physician verbally
__ Breastfeeding
__ **NONE**

Preferred Pharmacy Name: _____ **Telephone:** (___)___-____

Address (or cross street): _____ **City:** _____

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Patient Intake Form

This is a requirement by the government center for medical services based on the merit-based payment system.

Date: __/__/____

Print Name: _____

Are you a smoker? Current Former Never

Do you consume Alcohol? Yes No Occasional

Did you have a flu vaccine this year? Yes No

Have you ever had a pneumonia vaccine? Yes No

Do you have a living will? **Yes** **No**

Do you have an Advanced Directive / Power of Attorney? **Yes** **No**

Definition: a legal document expressing a persons wishes about critical care when he is unable to decide for himself.

*Name: _____

*Relationship: _____

*Phone Number: (___)___-____

Referring Physician / Primary Care Physician: _____

Signature: _____

Please initial on each line that you have read and understand each statement;

_____*I hereby authorize the release of any information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or for that portion not covered by my insurance. I further understand that if there is any delay or dispute regarding my insurance, I will be responsible for payment on my account within a reasonable period of time. I understand that I will be responsible for 100% of all cosmetic charges incurred in this office, regardless of any provider discount through my insurance carrier. I understand that it is my responsibility to obtain all necessary referrals from my PCP. If services are denied due to lack of referral, I am responsible for payment in full.

_____ *I understand that Specialist in Dermatology and Cosmetic Medicine has adopted strict Privacy Practices in Compliance with HIPAA regulations. Specialist in Dermatology and Cosmetic Medicine reserves the right to change its practice to maintain compliance with privacy regulations. More complete review of their privacy practices are available upon request. In the event of an emergency, Specialist in Dermatology and Cosmetic Medicine will disclose information related to your emergency condition.