

PATIENT ACCOUNT NUMBER

Phys:	
Rec'd by:	

PATIENT INFORMATION

(Please Print)

Today's Date ___ / ___ / ___

Name _____
Last First M.I.

Address _____
Street Apt # City State Zip

Home Phone () _____ **Cell Phone** () _____ Work Phone () _____

Email Address _____ **S.S. #** _____

Marital Status: Single Married Separated
 Divorced Widowed

Date of Birth ___ / ___ / ___ Age ___ Sex _____

Employer _____ Address _____

Accompanying Parent (if minor) _____

SUBSCRIBER INFORMATION

Name _____
Last First M.I.

Address _____
City State Zip

Home Phone () _____ **Cell Phone** () _____ Work Phone () _____

Employer _____ Address _____

Date of Birth ___ / ___ / ___ Sex _____ S.S.# _____

INSURANCE INFORMATION (Please present insurance card at time of check-in.)

Primary Insurance Name _____ Secondary Insurance Name _____

Ins. Address _____ Ins. Address _____

Policyholder _____ Policyholder _____

Insured's ID# _____ Grp # _____ Insured's ID# _____ Grp # _____

SS # _____ Date of Birth ___ / ___ / ___ SS # _____ Date of Birth ___ / ___ / ___

Relationship of patient to the Insured _____ Relationship of patient to the Insured _____

Insured Employer Name _____ Insured Employer Name _____

Insured Employer Address _____ Insured Employer Address _____

Insured Employer Phone () _____ Insured Employer Phone () _____

PHARMACY of CHOICE _____ **PHONE** () _____

ADDRESS _____

Referring Doctor _____ **Family Doctor** _____

Address _____ Address _____

Phone _____ Phone _____

I authorize the release of medical information to my primary care or referring physician, to consultants, if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to physician.

In order to establish optimal relations with patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services **at the time they are rendered** unless you are in a prepaid plan in which we participate. For these patients, applicable copayments and deductibles will be collected **at the time of service**. We accept payment in the form of cash, check or credit card. **If your insurance plan denies payment, you will be responsible for payment to our office. In the event that your check is returned "insufficient funds" or your account must be turned over to collections, a \$30.00 administrative fee will be added to your account.** Your signature below signifies your understanding and willingness to comply with this policy.

Signature / Guardian _____ **Date** ___ / ___ / ___

Chart # _____

MEDICAL INFORMATION

Patient Name _____ Date of Birth _____ Date _____

DESCRIBE CURRENT SKIN CONDITION _____

PAST/FAMILY/SOCIAL HISTORY

- 1) **Have you had skin cancer?** NO__ YES__ WHERE/WHICH TYPE? _____
- 2) **Do any family members have/had skin cancer?** NO__ YES__ WHICH TYPE? _____
- 3) **Have you recently been hospitalized or spent time visiting in a hospital?** NO__ YES__ EXPLAIN _____
- 4) **Do you wear sunscreen?** NO__ YES__
- 5) **Do you spend much time with your hands in water?** NO__ YES__
- 6) **Do any family members have the condition for which you are seeing us today?** NO__ YES__ WHO? _____
- 7) **Do you or any family members have seasonal allergies or asthma?** NO__ YES__ RELATIONSHIP _____
- 8) **Do you work outdoors, spend a significant amount of time in the sun or use a tanning bed?** NO__ YES__
- 9) **Do you drink alcohol?** NO__ YES__ SOCIAL__ EXPLAIN _____
- 10) **Do you smoke?** NO__ YES__ IF SO, HOW MUCH _____
- 11) **Do you have an advanced directive?** NO__ YES__

REVIEW OF SYSTEMS

- | | | | |
|-----------------------------|---|-------------------|---------------------------------|
| ___ Heart Problems | ___ Thyroid Disease | ___ Diabetes | ___ H/O Drug or ETOH Dependency |
| ___ Pacemaker/Defibrillator | ___ Kidney Disease | ___ Anemia | ___ Hepatitis-type _____ |
| ___ High Blood Pressure | ___ Venereal Disease | ___ Seizures | ___ Scar Easily |
| ___ Heart Valve/Stent | ___ Arthritis | ___ Depression | ___ Seasonal Allergies |
| ___ High Cholesterol | ___ Cold Sores | ___ Anxiety | ___ Emphysema |
| ___ Easy Bleeding | ___ Poor Healing | ___ HIV/AIDS | ___ Asthma |
| ___ Lupus | ___ Artificial Joints/Replacements- type and year _____ | | |
| ___ Glaucoma | ___ Currently Pregnant | ___ Breastfeeding | |

LIST OTHER CURRENT MEDICAL PROBLEMS: _____

MEDICATION

Have you taken any **ASPIRIN, PLAVIX, COUMADIN, PERSANTINE, HEPARIN, MOTRIN, ADVIL, FISH OIL** or other pain relievers or Arthritis medications in the last TWO weeks? NO__ YES__ Please List: _____

Do you require premedication before surgical procedures? NO__ YES__

MEDICAL ALLERGIES AND REACTION: _____

CURRENT MEDICATIONS (include OTC and Herbal): _____

PHARMACY OF CHOICE: _____ PHONE #: _____ FAX# _____

REFERRING DR: _____ PHONE #: _____ FAX# _____