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. # _____

Date of Birth ___/___/___ Age ___ Sex ___ **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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# _____