Associates in Dermatology

Patient: ______________________________ **DOB:** __________ **Gender:** M F **SSN:** _________________

Address: _______________________________________ **City/State/Zip**: ___________________________

Phone: ( ) _____________________ ( ) ________________________________
Home **Cell**

Email: ____________________________

Preferred Language: ___________ **Marital Status:** S M W D **Spouse's Name**: ______________________

Employer: __________________ **Occupation**: _______________ **Work Phone**: ________________________

May we leave a message on your answering machine with test results? Y N

May we access your medication history from your pharmacy? Y N

Please list any other person we may discuss your healthcare with:

____________________________ Relationship: _______________ Phone: _______________

_________________________________ Relationship: _______________ Phone: _______________

Information	Primary Insurance	Secondary Insurance	Tertiary Insurance
Name of Insurance			
ID Number			
Group Number			
Policyholder			
Policyholder Date of Birth			
Relationship to Patient			

I hereby assign my insurance benefits to be paid to Associates in Dermatology. I authorize the release of information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or the portion not covered by my insurance. I further understand that if there is a dispute regarding my insurance claim, I will be responsible for payment of my account within a reasonable time. I do acknowledge that Associates in Dermatology has provided me the opportunity to review its HIPAA Notice of Privacy Practices and I may request a copy of this document anytime.

Signature: ___________________________ **Date:** ___________

Relationship to Patient: _____________________________________

Associates in Dermatology Health History

Patient Name: ________________________ **DOB:** ________________ **Preferred Phone #:** ____________________

Skin Problem and Location ____

Medication Allergies ____

Current Medications ____

____

Pharmacy and Phone ____

How did you hear about our office? Physician / Referral Service / Relative / Friend / Ins. Co./ Internet / Other

Primary Care Physician: ____________________ **Phone:** ________________ **Referring Physician**: _______________

Do you have or have you had any of the following?

Anxiety	Y N	End Stage Kidney Disease	Y N
Arthritis	Y N	Hepatitis: if yes A B C	Y N
Asthma	Y N	High Blood Pressure	Y N
Cancer (non-skin) If yes, specify type	Y N	High Cholesterol	Y N
Coronary Artery Disease	Y N	HIV/AIDs	Y N
Depression	Y N	Hypo/Hyper Thyroid	Y N
Diabetes	Y N	Organ Transplantation	Y N

Other Medical Conditions/Surgeries:

____

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Skin Disease History: (please circle all that apply)
None / Actinic Keratosis / Basal Cell Carcinoma / Blistering Sunburns / Eczema / Melanoma
Psoriasis / Squamous Cell Carcinoma / Other ____

Please list dates and locations of Skin Cancers/Melanomas and treatments (except at our office)

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Do you have a family history of skin cancer, non-melanoma ? Y N
Do you have a family history of Melanoma (immediate relative?) Y N
Do you wear Sunscreen? Y N / Tanning Salon Use? Y N

Smoking History: (please circle one) Never Smoked // Currently Smoke / Former Smoker

Alerts

Problems with Bleeding	Y N	**Blood Thinners**	Y N
Problems with Healing	Y N	**Defibrillator/Pacemaker**	Y N
Problems with Scarring (Hypertrophic or keloid)	Y N	**Requires Antibiotics prior to procedure**	Y N
HSV/Cold Sores	Y N	**Pregnant/Trying to get Pregnant/Breastfeeding**	Y N
Rash	Y N	Other	Y N
Immunosuppression	Y N		