Associates in Dermatology

Patient: _____ **DOB:** _____ **Gender:** M F **SSN:** _____

Address: _____ **City/State/Zip**: _____

Phone: ( ) _____ ( ) _____
Home **Cell**

Email: _____

Race: (please circle) African American / Asian / Caucasian / Native American / Pacific Islander / Other / Prefer not to Answer

Ethnicity: (please circle) Hispanic / Non-Hispanic / Prefer not to answer

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: _____ Callback #: _____

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:

_____

_____

Skin Disease History: (please circle all that apply)
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)

_____

_____

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		