DERMATOLOGY ASSOCIATES, P.A

PATIENT INFORMATION FORM

Patient Name: ____________________

Address: ____________________

City: ____________ St.: ______ Zip: ____________

Date of Birth: ____________ SS#: ____________

Best phone number to be reached at: ____________________

Sex: M or F Marital Status: S M W D Spouse's Name: ____________

Person Responsible for Account: ____________ Relationship: ____________

Address: ____________________

City: ____________ St.: ______ Zip: ____________

Employer: ____________ Position: ____________

Work Phone#: ____________ Parent/Spouse Employer: ____________

Position: ____________ Work Phone: ____________

Notify in Case of Emergency: ____________ Relationship: ____________

Phone #: ____________ Referred by: ____________

Primary Insurance Information:

Insurance Company: ____________ Insured Name: ____________

Relation to Patient: ____________ DOB ________ Policy # ____________

Group #: ________ Co-Pay Amount: ________

Address if different from Patient: ____________________

Employer: ____________________

Secondary Insurance:

Insurance Company: ____________ Insured Name: ____________

Relation to Patient: ____________ DOB ________ Policy# ____________

Group #: ________ Co-Pay Amount: ________

PLEASE READ AND SIGN

I hereby authorize payment of medical benefits directly to physician of benefits due me or my dependents for the services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

____________________ Signature ____________ Date

I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information.

____________________ Signature ____________ Date

FOR INTERNAL OFFICE USE ONLY

Documentation of attempt to obtain acknowledgement of receipt of Notice of Privacy Practices

An attempt was made to obtain acknowledgement of receipt of the Notice of Privacy Practices on: ____________

The acknowledgement was not obtained because: The patient declined to sign the acknowledgement

Other: ____________________

____________ Name of Patient ____________ Name of Staff Member ____________ Date

MEDICAL INFORMATION

PATIENT NAME ______________________________ DATE ____________________

FAMILY DOCTOR __________________ REFERRING DOCTOR ____________________

RACE ________ AGE ________ MARITAL STATUS ____________________________

I. Nursing History (To be filled in by the nurse)

Chief Complaint ____

____

History of Present Illness: ____

____

____

____

____

II. Patient History (To be filled in by the patient)

SURGERY DATE

Previous surgeries or operations: 1. ____

2. ____

3. ____

4. ____

5. ____

Medications you take now:

NAME DOSE HOW OFTEN

1. ____
2. ____
3. ____
4. ____
5. ____

Allergies: List any medications you are allergic to

1. __________________________ 3. __________________________

2. __________________________ 4. __________________________

List any other allergies (e.g. hay fever, poison ivy, etc.)

1. __________________________ 3. __________________________

2. __________________________ 4. __________________________

(Over)

Medical History: Please list any medical problems you have had, such as cancers, heart attacks, strokes, infections, skin diseases, etc.

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Consumption Of The Following:

Aspirin: Amt. Daily ________ Amt. Weekly ________

Alcohol: Amt. Daily ________ Amt. Weekly ________

Tobacco: Amt. Daily ________ Amt. Weekly ________

Review of Systems:

Any medical problems with any of the following (if yes, please explain):

No Yes Head

No Yes Eyes

No Yes Ears, Nose, or Throat

No Yes Thyroid

No Yes Lungs

No Yes Heart

No Yes Blood or Blood Vessels

No Yes Digestive System

No Yes Liver

No Yes Muscles, Bones

No Yes Reproductive Organs

No Yes Kidneys, Bladder

No Yes Skin

No Yes Bleeding Problems

No Yes Local anesthesia (Lidocaine or Xylocaine)

No Yes Pregnant Now? If yes, Due Date____________ Physician ____________________

Family History: Please list any family history of medical problems.

Medical Condition **Family Member(s) Affected**

1. Skin Cancer ____
2. Skin Disease (please list) ________________________________
3. Other Cancer ____
4. Heart Problems ______________________________________
5. Asthma ____
6. Hay Fever ____
7. Other ____