

PATIENT

This section refers to the PATIENT ONLY (make corrections as necessary)

Name:	Sex:	Date of Birth:
Address:		
City, State, Zip:	SSN#:	
Home Phone:	Cell Phone:	
Referred By:	Phone:	
Employer:	Work Phone:	
Address:	City, State, Zip:	

RESPONSIBLE PARTY

Review/complete if person responsible for the bills is NOT the PATIENT!

Name:	Sex:	Date of Birth:
Address:		
City, State, Zip:	SSN#:	
Home Phone:	Work Phone:	Employer:

INSURANCE

Please list required information pertaining to your insurance coverage. If you have multiple coverage, supply information for both carriers.

Pri Carrier:	Sec Carrier:
Insured:	Insured:
Date of Birth: SSN#:	Date of Birth: SSN#:
Patient Relationship:	Patient Relationship:
Insured ID#:	Insured ID#:
Group #:	Group#:
Insurance Address:	Insurance Address:
Copay:	Copay:

PHONE CALLS

Do we have your permission to:

Leave a message on your answering machine at home?	___ Y ___ N
Leave a message at your place of employment?	___ Y ___ N
Discuss your medical condition with a member of your household	___ Y ___ N
If yes, whom? _____	
Relationship? _____	

AUTHORIZATION

I hereby give **Dermatological Care** my consent to any necessary medical evaluation and treatment. I hereby authorize release of information by or between any of my treating physicians; to my insurance company to process my claim and authorize payment directly to **Dermatological Care**, benefits otherwise payable to me. I understand I am financially responsible for charges not paid in a timely manner by my insurance. The above information is correct to the best of my knowledge.

Signed: _____ Date: _____

Dermatology Medical History

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 3. _____ 5. _____
 2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? YES NO
 Has anyone in your family had skin cancer? YES NO
 Do you have a history of any specific skin diseases? YES NO If yes, _____
 Do you have problems with healing YES NO
 Do you develop keloids (scars) after surgery YES NO
 Do you bleed easily? YES NO
 Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin
 Other _____

Social History:
 Do you drink alcohol? YES NO If YES _____ drinks per day
 Do you use IV drugs? YES NO If YES, what? _____ How often? _____
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS)? YES NO

Please answer the following questions:
 (Women) Are you pregnant? YES NO Due Date: ____/____/____
 What is your occupation? _____ Hobbies? _____

Completed by: Patient _____ / / _____
 Med. Assist _____ Signed by Patient _____ Date _____ Updated _____ Init _____
 Initials _____
 Reviewed by _____ / / _____
 Date _____ Updated _____ Init _____

Dermatological Care, Inc.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

____ Accepted _____ Denied

Signature _____

Date: _____