

DERMATOLOGY AND SKIN CANCER CENTER

Date: _____

Account No. _____

Office Use Only:

Please Complete ALL Information on Front and Back of Form
PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST AT THE FRONT DESK

Patient Name: _____
(Last) (First) (MI)

Physical Address: _____
(Street No.) (Apt. No.) (City) (State) (Zip Code)

Mailing Address: _____
(Street No.) (Apt. No.) (City) (State) (Zip Code)

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

Sex: M F Race: _____ Marital Status: _____ Birthdate: _____ Age: _____

Social Security #: _____ Disabled? _____ Retired ? _____

Please fill out the following information if Patient is a minor:	
Parent/Guardian's Name: _____	Relationship: _____
Parent/Guardian's Social Security No. _____	Parent/Guardian's Birthdate: _____

Emergency Contact: _____	Relationship: _____	
Home Phone: () _____	Cell Phone: () _____	Work Phone: () _____

Patient's Employer (Parent/Guardian's employer if patient is a minor): _____

Employer Address: _____
(Street/Box) (City) (State) (Zip Code)

Primary Insurance: _____ Policy Holder _____

Secondary Insurance: _____ Policy Holder _____

Spouse's Name: _____ Spouse's Employer: _____

Referred By: _____ Phone Book? Y N Newspaper? Y N



Known Allergies: _____

What is the problem? _____

Where is your problem located? _____

How long have you had this problem? _____

Have you been treated by another doctor for this problem? Y N

If Yes, who and when? _____

List Previous Hospitalizations/Surgeries/Serious Injuries **When?**

Patient Social History (Please Circle)

Marital Status: Single Married Separated Divorced Widower

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously but quit Current packs per day _____

Use of Drugs: Never Type/Frequency: _____

Excessive exposure at home or work to: Fumes Dust Solvents Noise

Pregnant? Yes No If Yes how far along? _____

Do you plan to become pregnant? Yes No

Family Medical History

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Authorization & Acknowledgement

I authorize the release of any medical information necessary to process medical claims and request payment of Medicare and other insurance benefits to the party who accepts assignment. I authorize payment directly to the provider of care shown. I understand I am financially responsible to charges not covered by this assignment. I agree that a photographic copy of this authorization shall be valid as the original. **I also authorize submission to the pathologist who will bill separately. In addition, I acknowledge that I have received a copy of the Notice of Privacy Practices for this medical practice. We reserve the right to modify the privacy practices outlined in the notice.**

Patient Signature: _____

Relationship to Patient: _____

(Parent or Guardian must sign if patient is a minor)

Have you ever had the following?

Diabetes.....	Yes	No
Hypertension.....	Yes	No
Cancer.....	Yes	No
Stroke.....	Yes	No
Heart Trouble.....	Yes	No
Arthritis/Gout.....	Yes	No
Convulsions.....	Yes	No
Bleeding tendency..	Yes	No
Acute infection.....	Yes	No
Venereal disease....	Yes	No
HIV or AIDS.....	Yes	No
Hepatitis B or C.....	Yes	No

List Medications you're taking:

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____
- 5.) _____
- 6.) _____
- 7.) _____
- 8.) _____
- 9.) _____
- 10.) _____