Dermatology

**PATIENT INFORMATION**

Name: ______________________ ____ ______________________
First Name MI Last Name

Date of Birth: _____/_____/_____ Sex: Male / Female / Declined SSN: ____-____-________

Race: ______________ Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined

Marital Status: Single Married Divorced/Separated Widowed

Address: ______________________ ____ ______________ __________ ____________
Street Apt # City State Zip Code

Phone Numbers: (____) ____________________ (____) ____________________
Home Cell

Email Address: ________________________________

Would you like to receive e-mails regarding special events and discounted cosmetic services? YES/NO

Preferred Method of Contact: Phone E-mail Letter

**EMERGENCY CONTACT**

Name: ______________ Phone #: (____) ______________ Relationship:__________

Is it okay to give your emergency contact your Biopsy Results? YES/NO

**MEDICAL INSURANCE (S)**

Primary Insurance Co: ______________ ID #: ______________Group #: ________

Claims Address: ________________________________________________

Policy Holder Name:________________________Date of Birth: ______________

Relationship to Policy Holder: ______________________________________

Employer of Policy Holder:________________ Phone: ______________________

Address:_________________________________________________________

Secondary Insurance Co: ____________ ID #: ______________Group #: ________

Claims Address: ________________________________________________

Policy Holder Name:________________________Date of Birth: ______________

Relationship to Policy Holder: ______________________________________

Employer of Policy Holder:________________ Phone: ______________________

Address:_________________________________________________________

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office my release record of my treatment to my insurance company or other third parties responsible for the payment of my medical charges.

**Patient Signature**: ______________________________ **Date**: ______________

**PRIMARY CARE PHYSICIAN**

Full Name: ______________________________ Did this Doctor refer you? YES/NO
Office Phone: ____________________________ Office Fax: ________________________

**PREFERRED PHARMACY**

Name: _________________________ Phone: (________)__________________ Fax: (________)__________________

Cross Streets: ___________________________________ and ___________________________________

**PAST MEDICAL HISTORY**

(Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease

Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol

Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other:

NONE

**PAST SURGICAL HISTORY**

(Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass/ CABG
Mechanical Valve Replacement
Biological Valve Replacement
Knee Replacement (Right, Left, Bilateral)
NONE

Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Cancer
Prostate Biopsy
TURP
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Heart Transplant
Hip Replacement (Right, Left, Bilateral)

A to Dermatology

**SKIN DISEASE HISTORY**

(Please circle all that apply)

| | | |
|---|---|---|
| Acne | Eczema | Poison Ivy |
| Actinic Keratosis | Flaking or Itchy Skin | Pre-Cancerous Moles |
| Basal Cell Carcinoma | Hay Fever/Seasonal Allergies | Psoriasis |
| Blistering Sunburns | Melanoma | Squamous Cell Carcinoma |
| Dry Skin | Skin Cancer- non melanoma, type unknown | NONE |

**SUNSCREEN**

(Please circle responses)

Do you wear sunscreen? Yes No if Yes, what SPF?

Do you tan in a tanning salon? Yes No

**MELANOMA**

(Please circle responses)

Have you ever been diagnosed with Melanoma? (Please note, not all skin cancers are melanoma) Yes No

If YES, did you ever have (Please circle all that apply): X-Ray CT Scan MRI PET Scan

Do you have a family history of Melanoma? Yes No If Yes, which relative(s)? ______________

**CURRENT MEDICATIONS**

| Name of Drug | Strength | Frequency |
|---|---|---|
| ______________________ | ________________ | ______________________ |
| ______________________ | ________________ | ______________________ |
| ______________________ | ________________ | ______________________ |
| ______________________ | ________________ | ______________________ |
| ______________________ | ________________ | ______________________ |
| ______________________ | ________________ | ______________________ |
| ______________________ | ________________ | ______________________ |
| ______________________ | ________________ | ______________________ |

Dermatology

**CURRENT DRUG ALLERGIES**

Name of Drug/Object — Reactions (CHECK ONLY THOSE THAT APPLY)

| Name of Drug/Object | Anaphylaxis | Diarrhea | Fatigue | Upset GI | Hives | Liver Toxicity | Rash | Other |
|---|---|---|---|---|---|---|---|---|
| ________ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ______ |
| ________ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ______ |
| ________ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ______ |
| ________ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ______ |
| ________ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ______ |
| ________ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ______ |

**REVIEW OF SYSTEMS**

(CHECK ONLY THOSE THAT APPLY)

☐ Problems with Bleeding
☐ Problems with Healing
☐ Problems with Scarring (hypertrophic or keloid)
☐ Rash
☐ Acne/Eczema
☐ Depression

☐ Facial Flushing
☐ Headaches
☐ Abdominal Pain
☐ Fever or Chills
☐ Cough
☐ Sore Throat

☐ Joint Aches
☐ Thyroid Problems
☐ Chest Pain
☐ Joint Pain
☐ Muscle Weakness
☐ Blurry Vision

☐ Bloody Stool
☐ Immunosuppression
☐ Hay Fever/Seasonal Allergies
☐ Night Sweats
☐ Unintentional Weight Loss
☐ Bloody Urine

☐ Neck Stiffness
☐ Seizures
☐ Shortness of Breath
☐ Wheezing
☐ Anxiety

**SOCIAL HISTORY**

(Check those that apply)

Smoking Status

☐ Current every day smoker
Cigarettes per day ________

☐ Current someday smoker

☐ Former smoker
Year quit ________

☐ Never Smoker

Alcohol Use

☐ 3 or more drinks per day

☐ 1-2 Drinks per day

☐ Less than 1 drink per day

☐ NONE

Caffeine Use

☐ Several cups a day

☐ One cup a day

☐ NONE

**HIPAA Authorization Form**

(Permission from patient/patient's legal guardian to share personal medical information)

Patient Name: ______________________________________________

DOB: ________/____________/____________

Street Address: _____________________________________________

City, State, ZIP code:_________________________________________________

I, ______________________________________, hereby authorize A to Z Dermatology and/or associated medical
Name of Patient
facilities to release any and all medical information and test results that pertain to me, to the following individuals (s):

Name:___________________________ Phone:____________________ Relationship to pt:_________________

Name:___________________________ Phone:____________________ Relationship to pt:_________________

Name:___________________________ Phone:____________________ Relationship to pt:_________________

I authorize A to Z Dermatology and/or associated medical facilities to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying A to Z Dermatology in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

______________________________________________ ___________________________
Signature of Patient Date

Or if applicable:

______________________________________________ ___________________________
Signature of Legal Guardian/Personal Rep of Patient's Estate Date