Patient: **First** _____**M.I.** ___ **Last** _____**Date of Birth:** _____

Address: _____ **City:**_____**State:** _____**Zip Code:** _____

Responsible Billing Party:_____**Social Security** #: _____ **DOB:** _____

Home_____**Work:** _____ **Mobile:** _____

Best Contact number for confirmation calls is: _____

Email (Required): _____

I would like to receive statements and communications through email. Y / N

Primary Ins: **Primary Card Holder:** _____ **DOB:** _____

ID#: Group#:

Secondary Ins: Primary Card Holder: _____ **DOB:** _____

ID#: Group #:

Reason for your visit: _____

Past Skin History *(Please check the applicable boxes to the patient's history or choose the first box)*

	✓	Previous Treatments	Treating Physician	Notes
No significant skin history				
Eczema				
Urticaria/Hives				
Psoriasis				
Basal Cell Carcinoma				
Actinic Keratosis				
Squamous Cell Carcinoma				
Malignant Melanoma				
Other Skin Cancer				
X-Ray Therapy				
Wounds that bleed easily or do not heal				
Ulcers				

Pneumovax/Influenza History (Required)

Have you received a pneumonia vaccination in the past? **Yes ( )** **No ( )**

Have you received the Influenza vaccination? **Yes ( )** **No ( )**

List reason for not having vaccinations if any: _____

Past Medical History *(Please check the applicable boxes to the patient's history or choose the first box)*

	✓	Details
No Pertinent Past Medical History		
Arthritis		
Anemia		
Bleeding Disorders		
Asthma		
Hay Fever		
Tuberculosis, Emphysema or Lung Disorder		
Skin Cancer		
Breast Cancer		
Other Cancer		
High Cholesterol		
High Blood Pressure		
Heart Disease		
Chest Pain/Tightness		
Heart Murmur		
Congenital Heart Defect		
Rheumatic Fever		
History of Endocarditis/Heart Infection		
Diabetes		
Stroke		
Gastrointestinal Disease		
Hepatitis, Jaundice or other Liver Problems		
Compromised Immune System (HIV, AIDS, Lupus)		
Sexually Transmitted Disease		
Neurological Disorder		
Kidney Stones		
Thyroid Disorder		
Ulcers		

Past Surgical History *(Please check the applicable boxes to the patient's history or choose the first box)*

	Surgery	Date	Notes/Detail
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Family History (*Please choose the applicable boxes to the patient's family or choose the first box)*

	✓	Afflicted Family Member	Notes
No Contributing Family History			
Adopted			
Autoimmune Disorders			
Colon Cancer			
Diabetes			
Glaucoma			
High Blood Pressure			
High Cholesterol			
Liver Disease			
Lung Disease			
Malignant Melanoma			
Obesity			
Premature Coronary Heart Disease			
Skin Cancer			
Thyroid Disease			

Demographics (Required)

Race: _____

Ethnicity: _____ (Hispanic/Non-Hispanic, etc.)

Language: _____

Allergies

If none, please write "None" for Allergies

	Allergy	Reaction	Notes
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Current Medications

If none, please write "None" for Medications

	Medication	Dosage	Prescribed By
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Please list your preferred Pharmacy (include city): _____

Social History (Required)

Alcohol

Do you drink alcohol? Yes ( ) No ( )
If yes:
How many days per week do you drink? ***1 2 3 4 5 6 7***
How many drinks per occasion? _____

Smoking Status

Smoking status: ( ) Current smoker ( ) Non-Smoker ( ) Chewing Tobacco

If a previous or current smoker/chewing tobacco:

When did you start? _____

When did you quit? _____

Height/Weight

	Details
Height (Feet)	
Height (inches)	
Weight	

Cosmetic Interest

Are you interested in discussing treatment options for any of the following conditions?

Facial Wrinkles	**Y**	**N**
Sun Spots/Freckles	**Y**	**N**
Age Spots	**Y**	**N**
Dark circles under your eyes	**Y**	**N**
Facial Redness/Veins	**Y**	**N**
Leg Veins	**Y**	**N**
Tattoo Removal	**Y**	**N**

Verification – All information provided above is accurate and complete to the best of my knowledge

_____ _____ _____

Patient Signature **Parent or Guardian Signature (Minors)** **Date**

Notice of Privacy Practices Acknowledgement

I am a patient of: **Dr. Del Torto/Dr. Stranahan/Dr. Brandon/Erica Franks, PA-C**.

I hereby acknowledge receipt of Easton Dermatology's Notice of Privacy Practices.

Name [**please print**]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____.

(Print Patient Name)

I hereby acknowledge receipt of Easton Dermatology's Notice of Privacy Practices with respect to the patient.

Name [**please print**]: _____

Relationship to Patient: ○Parent ○Legal Guardian

Signature: _____

Date: _____

Date:
Patient Name: **DOB:**

With your approval, we may disclose your personal health information to designated family, friends and others involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care.

By signing this authorization, I allow Easton Dermatology Associates, L.L.C., to discuss with the persons named below my personal health information which may include, but is not limited to, biopsy results, culture results, diagnosis, treatment plan, billing status and appointment status. This may be done in person or by telephone.

By signing this authorization, I understand the following:

This applies to services being rendered to me by the physicians and non-physician providers who practice under the name of Easton Dermatology Associates L.L.C.

Once this information is released to the designated family member, friend or other person named below, the release information may no longer be protected by the federal privacy regulations.

This authorization is voluntary

I may withdraw this authorization at any time by notifying the Easton Dermatology Privacy Officer, Erica Franks, PA-C, in writing. If I do withdraw the authorization, it will not have any effect on actions taken by Easton Dermatology prior to receiving the written request.

I authorize discussion of my personal health information with the following person(s): **(PRINT CLEARLY)**

(1) Name:_____ Phone: _____

Relationship to Patient: _____

(1) Name: _____ Phone:_____

Relationship to Patient _____

FINANCIAL DISCLOSURE

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. Failure to make payment on any unpaid services can result in my account being sent to collections and/or legal action taken. If legal action is pursued, I will incur all court cost, attorney's fees and any other cost associated in the collection of this debt. I can also be discharged from the practice after a 30 day notice.

I understand that I am responsible for paying a $ 50.00 fee for dermatology appointments and $ 100.00 fee for surgery or laser appointments if I do not call to cancel or reschedule. In the event of two consecutive NO SHOW appointments, I understand that I can be discharged from the practice.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date