skinMD
Dermatology and Skin Enhancement Center

Last Name:_____ First Name:_____MI____ Title: Dr. Jr. Sr.

Date of Birth: _____ SS#_____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Contact information

May we leave a message?

Home Phone: (____)_____ YES / NO (home)

Cell Phone: (____)_____ YES / NO (cell)

Work Phone: (____) _____ Employer:_____ YES / NO (work)

Email address: _____

HHS(Department of Health and Human Services) requires providers to report race and ethnicity

Race: American Indian / Alaska Native / Asian / Black or African American / Caucasian

Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Preferred Language: _____

Referral/Doctors information

How did you find our office? _____ (ie. insurance company, friends/family, internet search, phone book)

Primary Care Physician: Last Name _____ First Name _____ Phone# _____

Did your PCP refer you? Yes / NO

If No, please provide referring doctors information:

Last Name _____ First Name _____ Phone# _____

Which Pharmacy do you use? _____

Insurance Information:

Insurance Company / Policy number: _____

Policy Holder's Name: _____ **Relationship to patient: Self / Spouse / Parent / Other**

Policy Holder's Date of Birth: _____ Policy Holder's SSN# (Tricare only): _____

Secondary Insurance and Policy Number: _____

If patient is a minor: *Parents Name:* _____ *Birth Date:* _____ *Phone:* _____

Please list name and phone number of anyone you would like to authorize us to speak with regarding your medical care

*(This includes scheduling and cancelling appointments, inquiring on billing and insurance; anyone not listed will **not** be spoken with)*

Name(s): _____ Phone: _____

Emergency Contact same as above? **Yes / No** if no please provide information:

Name: _____ Relationship_____ Phone:_____

Signature: _____ **Date:** _____

Name: _____ **EMA History and Intake Form**

Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (benign prostate hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD(chronic obstructive pulmonary disease)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Gastroesophageal reflux disease)
Hearing Loss
Herpes Simplex (Cold Sores/Genital Herpes)
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other _____

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: Inflammatory bowl disease
Gallbladder Removed
Coronary Artery Bypass
PTCA(Percutaneous transluminal coronary angioplasty)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement: Knee(Right, Left, Bilateral)
Joint Replacement: Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (transurethral resection of prostate)
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Where? _____
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Herpes Simplex
Melanoma
Where? _____
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Where? _____
None

Other _____

- **Do you wear Sunscreen?** **Yes** **No**

If yes, what SPF? _____

- **Do you currently tan in a tanning salon?** **Yes** **No**

Have you **ever** tanned in a tanning salon? **Yes** **No**

- **Do you have a family history of Melanoma?** **Yes** **No**

If yes, which relative(s)? _____

- **Do you have any family history of any other skin cancer?** **Yes** **No**

If yes, which kind? Basal Cell Carcinoma Squamous cell carcinoma

Medications: (Please enter all current medications, or provide a medication list)

_____

_____

Allergies: (Please list all allergies)

_____

_____

Immediate family medical history: (parents, siblings and children)
(Example: heart disease, kidney disease, diabetes, cancer)

_____

_____

Cigarette Smoking: (Circle all that apply)	**Alcohol Intake:** (Circle all that apply)
Never smoked	None
Quit: former smoker	less than 1 per day
Smokes less than daily	2-3 drinks per day
Smokes daily	more than 3 drinks per day

- **Females: Are you currently pregnant/breastfeeding?**

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding/blood thinners		
Problems with healing		
Problems with keloid scars		
immunosuppression		
Fever/chills		
Unintentional weight loss		
Joint aches		
Anxiety		

Other Symptoms: _____

Do you have any pain related to your skin problem today?
(Circle one)

0 1 2 3 4 5 6 7 8 9 10

(no pain) *(extreme pain)*

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Notice of Privacy Practices-Patient Acknowledgement

The staff at Skin MD Dermatology and Skin Enhancement Center are committed to safeguarding the privacy and confidentiality of your medical record, including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Signature below indicates you have been aware of the privacy policies of Skin MD Dermatology and Skin Enhancement Center and have received (or have been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Financial & Information Release

Payment is expected at the time of service; insurance co-payments are mandated by your insurance company and MUST be made today. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I understand and agree that if the insurance company denies benefits for any reason; I am responsible for the full amount of service provided. I understand that the definition of "non-covered" cosmetic procedures is made solely by my insurance company.

I request the payment of authorized insurance/ Medicare benefits be made payable to Skin MD Dermatology and Skin Enhancement Center (FEIN 27-0924989) on my behalf for services furnished to me. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection including attorney fees, collection fees and court costs and understand that I am no longer a patient of this office. I understand and agree to pay a returned check charge of $40.00 per returned check for any reason.

I authorize any holder of medical information about me to release any and all information to the health care financing administration, its agents, or my insurance carrier as needed to determine these benefits or the benefits for myself or my dependents. If I have health insurance coverage under an HMO or it is requested by any of my physicians, I authorize Skin MD Dermatology and Skin Enhancement Center to release information concerning my diagnoses and treatment to my primary care of referring physician after each visit.

Signature of PATIENT (parent) or INSURED: _____

Date: _____

Skin MD
Dermotolgy and Skin Enhancement Center
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