INTEGRATED
DERMATOLOGY
OF TIDEWATER

PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DEMOGRAPHICS
Preferred Called Name: ______________________________ Age: ___________________________________

Last Name: __________________________________ First Name: ___________________________MI: _______

Date of Birth: ________________________________ Social Security: __________________________________

CONTACT
Home: ______________________ Work: ___________________________ Cell: ___________________________

May we leave a detailed message? ☐ Yes ☐No IF YES, please circle preferred number.
Email: ____

May we email you for appointment reminders, confidential results, promos, etc? ☐Yes ☐No

ADDRESS
Address: ____

City: _______________________ State: ______________________ Zip: ___________________________________

EMERGENCY CONTACT
Last Name: ___________________________________ First Name: ______________________________________

Phone Number: _______________________________ Relationship to Patient: __________________________

PRIMARY PHYSICIAN
Physician Name: ______________________________ Physician Phone: ________________________________

Physician Address: ____

PREFERRED PHARMACY
Pharmacy Name: ______________________________ Address: _______________________________________

Pharmacy Phone: _____________________________ Pharmacy Fax: ___________________________________
REFERRAL
How did you hear about us? If so, who may we thank? ____

REWARDS

Are you a member of Brilliant Distinctions or Xperience? (Injectable rewards programs) If not, May we sign you up using your email address? Y or N

REASON FOR TODAY'S VISIT:

____

Pregnant or Nursing? Y or N

Keloid scarring? Y or N

Latex Allergy? Y or N

Smoker? Y or N Current Former

ALLERGIES Y or N

Medication Allergies (please list): ____

MEDICATIONS

Prescription medications (please list): ____

Over-the-counter medications, herbals, vitamins (please list): ________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have reviewed and understood the Notice of Privacy Practices. I know I have a right to obtain a copy for my records.

CONSENT FOR EVALUATION, EXAMINATION, AND TREATMENT

By signing below, I authorize the evaluation, examination, and treatment by Emily Patrick, RN. I understand that there are risks to any procedure, including, but are not limited to:

- Bleeding
- Pain
- Infection
- Scar
- Discoloration (Temporary or permanent)

CANCELLATION POLICY:

We require a minimum of **24-hour notice** for appointment cancellation. Cancellations, rescheduling, or no-shows to your appointment after the 24-hour window will result in a fee of $25 for your first missed appointment, and $50 thereafter.

This authorization and consent shall remain in force for this and all future visits to Integrated Dermatology of Tidewater.

Patient Signature: ____

Patient Name (print): ____ Date: ____________________