DERMATOLOGY CENTER

Patient Information: Today's Date: _____

Patient Name: _____ Name you are called by: _____

Address(Physical) STREET: _____ CITY: _____ STATE: _____ ZIP: _____

Address(Billing) STREET: _____ CITY: _____ STATE: _____ ZIP: _____

Cell #: _____ Home #: _____ Birth Date: _____ SS#(Optional): _____

Email Address: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Social History:

Sex: ☐ Male ☐ Female **Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Race:** _____

Language Spoken at home: _____ **Marital Status:** ☐ Single ☐ Married ☐ Other: _____

Privacy: ☐ **YES** ☐ **NO** The Dermatology Center may leave messages on my answering machine or with a family member

☐ **YES** ☐ **NO** The Dermatology Center may release information to my spouse or family

☐ **YES** ☐ **NO** I would like to receive email updates and promotions from The Dermatology Center

Insurance Information:

Primary Insurance: _____ Ins. Address: _____

Policy Holder's Name: _____ ***Policy Holder's Birth Date:*** _____

ID #: _____ Group #: _____ Pts. Relationship to Policy Holder: _____

Secondary Insurance: _____ Ins. Address: _____

Policy Holder's Name: _____ ***Policy Holder's Birth Date:*** _____

ID #: _____ Group #: _____ Pts. Relationship to Policy Holder: _____

I authorize payment of insurance benefits, otherwise payable to me, directly to The Dermatology Center. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents. I authorize The Dermatology Center to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that payment in full for all charges is not made, I agree to pay for all costs of collection including a collection fee and court costs.

_____ _____

Date **Signature of Patient OR Guardian**

MEDICARE PATIENTS ONLY

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Date Signature of Medicare Patient OR Guardian

The Dermatology Center Medical History

Patient Name: _____ **Date of Birth**: ____/____/____ **Today's Date**: ____/____ /_____

Past Medical History (please mark all that apply)

☐	Anxiety	☐	COPD (Lungs)	☐	Hypertension (↑Blood Pressure)	☐	Prostate Cancer
☐	Arthritis	☐	Coronary Artery Disease	☐	HIV/AIDS	☐	Radiation Tx
☐	Asthma	☐	Depression	☐	Hypercholesterolemia(↑ cholesterol)	☐	Seizures
☐	Atrial Fibrillation	☐	Diabetes	☐	Hyperthyroidism	☐	Stroke
☐	BPH (Enlarged Prostate)	☐	End Stage Renal Disease	☐	Hypothyroidism	☐	Other:
☐	Bone Marrow Transplant	☐	GERD (Reflux)	☐	Leukemia	☐	**NONE**
☐	Breast Cancer	☐	Hearing Loss	☐	Lung Cancer	☐	
☐	Colon Cancer	☐	Hepatitis	☐	Lymphoma	☐	

Past Surgical History (please mark all that apply)

☐	Appendix: Appendectomy	☐	Heart: Valve Replacement	☐	Ovarian Cancer	☐	Skin: Melanoma
☐	Bladder: Cystectomy	☐	Heart: Heart Transplant	☐	Prostate Cancer	☐	Spleen: Splenectomy
☐	Breast: Mastectomy R or L	☐	Joint Replacement **Knee R or L**	☐	Prostate Biopsy	☐	Testicles: Orchiectomy
☐	Colon: Diverticulitis	☐	Joint Replacement **Hip R or L**	☐	Prostate TURP	☐	Uterus: Hysterectomy
☐	Colon: Inflammatory Disease	☐	Kidney Stones	☐	Skin Biopsy	☐	Cervical Cancer
☐	Gallbladder	☐	Kidney Transplant	☐	Skin Basal Cell Carcinoma	☐	Other:
☐	Heart: Coronary Bypass	☐	Ovarian Cyst	☐	Skin: Squamous Cell	☐	**NONE**

Skin Disease History (please mark all that apply)

☐	Acne	☐	Blistering Sunburns	☐	Hay Fever/ Allergies	☐	Psoriasis
☐	Sun Spots (AKs)	☐	Dry Skin	☐	Melanoma (Mole Cancer)	☐	Squamous Cell Skin Cancer
☐	Asthma	☐	Eczema	☐	Poison Ivy	☐	Other:
☐	Basal Cell Skin Cancer	☐	Flaking or Itchy Scalp	☐	Precancerous Moles	☐	**NONE**

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family History of Skin Cancer? ☐ Yes ☐ No **If yes, which kind?**

☐	Basal Cell
☐	Squamous Cell
☐	Melanoma

If yes, which relative? _____

Do you have a family history of other medical conditions or diseases in your immediate family (parents, siblings or children)?

If yes, please list condition & family member _____

Medications (please list all medications you are currently taking)

Allergies (please list any allergies to medications)

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, _____ drinks per day

Smoking Status ☐ Never ☐ Former ☐ Current If current: ☐ Everyday ☐ Some days

Women Are you pregnant? ☐ Yes ☐ No Due Date: ____ /____ /____ Are you breastfeeding? ☐ Yes ☐ No

I certify that the above information is correct to the best of my ability.

I understand that with any surgical procedure during my visit, that: (1) All tissues removed are subject to pathology (2) This is a protection for you and your doctor (3) There are charges billed by the doctor reading the slide and (4) Charges are billed out the day the slides are read. I accept full responsibility for any related charges.

Date: _____ Patient/Guardian Signature:_____