CENTER FOR DERMATOLOGY
ERIK B. HURST, MD

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)		SOCIAL SECURITY #	
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL/ALTERNATIVE PHONE	
EMAIL ADDRESS			
SEX MALE FEMALE	MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED	DATE OF BIRTH	HAVE YOU BEEN SEEN IN THE OFFICE BEFORE?

POLICY HOLDER INFORMATION

PRIMARY INSURANCE INFORMATION		
INSURANCE COMPANY	NAME OF POLICY HOLDER	
ID NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER
POLICY HOLDER'S DATE OF BIRTH	POLICY HOLDER'S SOCIAL SECURITY NUMBER	
SECONDARY INSURANCE INFORMATION		
INSURANCE COMPANY	NAME OF POLICY HOLDER	
ID NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER
POLICY HOLDER'S DATE OF BIRTH	POLICY HOLDER'S SOCIAL SECURTIY NUMBER	

EMERGENCY CONTACT

NAME (LAST, FIRST, MI)	HOME PHONE
WORK PHONE	CELL/ALTERNATIVE PHONE

GUARANTOR/RESPONSIBLE PARTY

SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH
RELATIONSHIP	DAYTIME PHONE	
GUARANTOR NAME		
ADDRESS		

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any otherwise payable to me for his/her services as described, realizing I am responsible for non-covered services.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature: _____ Date: _____

MEDICAL HISTORY AND INTAKE FORM

DATE: _____
DOB: _____

PATIENT NAME:
_____
PRIMARY CARE PHYSICIAN:
_____
MEDICATION ALLERGIES:
_____
PHARMACY NAME:
_____
PHARMACY ADDRESS & PHONE NUMBER:
_____
_____
_____

PAST MEDICAL HISTORY:

Anxiety	COPD	Hypercholesterolemia
Arthritis	Coronary Artery Disease	Hyperthyroid
Asthma	Depression	Hypothyroid
Atrial Fibrillation	Diabetes	Radiation Treatment
Bone Marrow Transplant	Kidney Disease	Seizures
BPH (Enlarged Prostate)	GERD	Stroke
Cancer Types:	Hearing Loss	Other:
_____	Hepatitis	_____
_____	Hypertension	_____
_____	HIV/AIDS	NONE

HAVE YOU HAD SURGERY ON ANY OF THE FOLLOWING ORGANS: (please circle all that apply)

Appendix (Appendectomy)	Joint Replacement: Hip (Right)	Rectum: APR
Bladder (Cystectomy)	Joint Replacement: Hip (Left)	Rectum: Lower Anterior resection
Breast: Lumpectomy: _____	Joint Replacement: Hip (Both)	
Breast: Mastectomy: _____	Kidney: Kidney Biopsy	Skin: Biopsy
Breast: Breast Biopsy	Kidney: Nephrectomy	Skin: Basal Cell
Colon: Colon Cancer resection	Kidney: Kidney Stone Removal	Skin: Squamous Cell
Colon: Diverticulitis	Kidney: Kidney Transplant	Skin: Melanoma

Colon: Inflammatory Bowel Disease
Colon: Colostomy
Gall Bladder (Cholecystectomy)
Heart: Coronary Artery Bypass Surgery
Heart: PTCA
Heart: Mechanical valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement: Knee (Right)
Joint Replacement: Knee (Left)
Joint Replacement: Knee (Both)
Liver: Shunt
Liver: Liver Transplant
Liver: Hepatectomy
Ovaries: endometriosis
Ovaries: Ovarian Cyst
Ovaries: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreatectomy
Prostate Cancer
Prostate Biopsy
Prostate: TURP
Spleen: Splenectomy
Testicles: orchiectomy
Uterus: Fibroids
Uterus: uterine Cancer
Uterus: cervical cancer

OTHER:

_____

PLEASE FILL IN REVERSE SIDE OF SHEET ALSO

SKIN DISEASE HISTORY: (circle all that apply):

Acne
Actinic Keratosis
Asthma
Basal Cell Cancer
Blistering Sun Burns
Dry Skin
Eczema
Moles
Flaking or Itchy Scalp
Hay Fever/Allergies
Cancer
Melanoma
_____
Poison Ivy
Precancerous
Psoriasis
Squamous Cell
Other:

Do you wear sunscreen? _____ If yes, what SPF _____
Do you tan in a tanning salon? _____
Do you have a family history of melanoma? _____
If yes, which relative(s)? _____

SOCIAL HISTORY:

Smoking Status: (please circle one)
Current every day smoker
Former Smoker
Never Smoker

Alcohol Status: (please circle one)
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

REVIEW OF SYSTEMS: Do you have or are you currently experiencing any of the following? (Please circle all that apply)

Changing mole
Rash
Fever or chills
Depression
Anxiety
Problems with healing
Problems with bleeding
Problems with scarring
Muscle weakness
Neck stiffness
Headaches
Seizures
Cough
Shortness of breath
Wheezing
Pacemaker

Immunosuppression	Defibrillator
Hay fever	Blood thinners
Chest pain	GI upset with antibiotics
Night sweats	Premedication prior to procedures
Unintentional weight loss	Rapid heartbeat with epinephrine
Thyroid problems	pregnancy or planning a pregnancy
Sore throat	Allergy to adhesive
Blurry vision	Allergy to lidocaine
Abdominal pain	Allergy to topical antibiotic ointment
Bloody Stool	Artificial heart valve
Bloody urine	Artificial joint within the past 2 years
Joint aches	MRSA

IMMUNIZATIONS: Have you had the following immunizations?
Influenza (flu): _____ Date: _____
Pneumonia: _____ Date: _____
Varicella (Shingles) _____ Date: _____