DERMATOLOGY™
ASSOCIATES, P.A.

PATIENT INFORMATION - PLEASE PRINT

Full Name _____
(Last) (First) (Middle) (Maiden) Date

Mailing Address _____
(City) (State) (Zip)

Age _____ Date of Birth _____ _____Male _____Female
(Mo) (Day) (Yr)

Social Security Number _____ Marital Status S M D W
Home Phone _____ Personal Physician _____
Work Phone _____ Physician's Address _____
Alternate # _____ _____
Patient's Employer _____ Physician's Phone _____
Address _____ Referred by Doctor _____

RESPONSIBLE PARTY INFORMATION

Name _____ Address _____
Birthdate _____ Social Security No. _____Phone _____
Employer _____ Relationship to Patient _____

MEDICAL INSURANCE: **If your insurance policy requires a copayment, percentage, or deductible, this amount is payable at the time services are rendered. If our office is not a participating provider for your insurance or if a required referral has not been obtained, then payment is expected in full at the time of service.**

PRIMARY MEDICAL INSURANCE COMPANY: _____
NAME _____
ID NUMBER _____GROUP NUMBER _____
SUBSCRIBER BIRTHDATE _____ EMPLOYER _____
COPAYMENT/PERCENTAGE REQUIRED FOR OFFICE VISIT: $ _____

SECONDARY MEDICAL INSURANCE PLAN: _____
NAME _____
ID NUMBER _____ GROUP NUMBER _____
SUBSCRIBER BIRTHDATE _____ EMPLOYER _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION TO ABOVE INSURANCE COMPANIES

I, _____, hereby assign all medical and/or surgical benefits to Dermatology Associates, PA. This includes major medical benefits. Medicare and Government sponsored programs, private insurance or other.

This assignment of benefits will remain in effect until revoked by me in writing. I understand that I am responsible for all applicable COPAYMENTS, COINSURANCE, and NON-COVERED SERVICES as required by my insurance policy.

I hereby authorize DERMATOLOGY ASSOCIATES, PA, to release all information necessary, including medical records to secure the payment of insurance benefits.

SIGNATURE _____ **DATE** _____

OVER

PATIENT INFORMATION - PLEASE PRINT

Full Name _____
(Last) (First) (Middle) (Maiden) Date

Age _____ Date of Birth _____

HISTORY OF PRESENT ILLNESS

What is your current skin problem? (acne, mole, rash, etc.) _____
On what body area(s) is the skin problem located? _____
How long have you had this skin problem? _____
Describe any **symptoms** related to your skin problem: (itching, burning, pain, bleeding, etc.) _____
_____
Have the symptoms been: none mild moderate severe (circle one)
Describe any **treatments** that have been done (prescriptions, over the counter medication, surgery)
_____
_____
_____
_____

REVIEW OF SYSTEMS

Do you have any **symptoms** with any other body area(s) **related to your present skin condition**?
(Such as fever, headache, pain in muscles, joints, fatigue, depression, etc.)
_____
_____
Describe your general health: poor fair good excellent (circle one)

DO YOU HAVE:	•an artificial heart valve	yes	no
	•mitral valve prolapse	yes	no
	•an artificial joint (hip, knee)	yes	no
	•a heart pacemaker	yes	no
DO YOU TAKE:	•aspirin or coumadin	yes	no
	•arthritis medication (NSAIDS)	yes	no
ARE YOU:	•pregnant?	yes	no
	•breast-feeding	yes	no

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD:		
•Melanoma	yes	no
•Other skin cancer	yes	no
•Asthma (hay fever)	yes	no
•Eczema	yes	no
•Psoriasis	yes	no
•Lupus or autoimmune disease	yes	no
•Other cancer	yes	no

SOCIAL HISTORY

DO YOU:		
•smoke	yes	no
•use smokeless tobacco	yes	no
•use alcohol	yes	no

what is your occupation _____
_____

Medication Allergies:_____
(penicillin, sulfa, cephalosporins, local anesthetic, other)
_____

PAST MEDICAL HISTORY

List your CURRENT MEDICAL PROBLEMS (diabetes, hypertension, etc.):
_____
_____
_____

List any HOSPITALIZATIONS OR SURGERIES _____
_____
_____

CHILDBIRTH _____

List your CURRENT MEDICATIONS:

_____ _____ _____
_____ _____ _____
_____ _____ _____