THE DERMATOLOGY CENTER

Cell Phone #: _____ Carrier: _____

Name Of Patient: _____
Last First Middle Social Security#

Mailing Address: _____
Street City State Zip Code

Preferred Phone# _____ Work# _____

Email Address: _____ Date of Birth: _____

Occupation _____ Marital Status: S M W Sex: M F

Race: ASN BLK HSP WHT Other _____ Preferred Language: English Other _____

Preferred Pharmacy: _____ Address: _____

In case of emergency notify: _____
Name Relationship Phone#

Optional: **I authorize the release of information to the following person:** _____

If Minor - Information on Parent/Guardian Requesting Care:

Name: _____
Last First Middle Social Security#

Address (if different:) _____
Street City State Zip Code

Date of Birth: _____ Employer: _____

Preferred Phone# _____ Work# _____

Insured's Information (if different from Patient/Parent/Guardian)

Name: _____
Last First Middle Social Security#

Address (if different): _____
Street City State Zip Code

Date of Birth: _____ Employer: _____

Preferred Phone# _____ Work# _____

I authorize the Dermatology Center to release to my insurance company, its intermediaries or carriers any information needed for, or related to my claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the Dermatology Center.

I acknowledge that I am aware of the Centers privacy practice notice, and that I may have a written copy of such notice. I give the Center, it's employees and agents express consent to contact me by any means for the purpose of treatment, insurance or payments.

_____ _____ _____

Signature of Patient - Parent/Guardian Minor: Signature of Patient (14 -18 years of age) Date

*** * * * COMPLETE BACK OF FORM * * * ***

Health History

Family History: Circle any of the following that a blood relative has been treated for.

Cancer (non-skin)	Heart Disease	Melanoma
Depression	High Blood Pressure	Skin Cancer
Diabetes	Eczema	Psoriasis

Past Medical History: Circle any illnesses that you have been treated for.

Aids/HIV	Cancer	Heart Disease/Attack	Kidney Disease
Anemia	Diabetes	Hepatitis	Stroke
Arthritis	Easy Bleeding/Bruising	High Blood Pressure	Thyroid Disease
Asthma	GI/Bowel Disease	High Cholesterol	Tuberculosis

Other Prior Illnesses: _____

Previous Surgeries: _____

_____

Medications you are taking: _____

_____

Social History:

Do you smoke tobacco? **YES** # Packs per day _____ #Years _____ **NO**

Former smoker # Packs per day _____ Date Quit: _____ #Years _____

Do you drink alcohol?	Never	Socially	Daily	
Do you use a tanning bed?	Yes	No	Previously Used	
Do you use sunscreen?	Daily	Sometimes	Always, if sunny	Rarely/Never

Do you have an Advance Directive/Living Will? YES NO

Review of Systems: Circle any of the following that you have been treated for in the past year.

Weight loss/gain	Blood in urine	Depression
Dry Eyes	Arthritis	Diabetes
Mouth Sores	Skin cancer	Anemia
Chest Pain	Rash	Allergies
Chronic Cough	Migraines	Chronic Diarrhea

Flu Vaccination

Drug Allergies: None Known Yes, list: _____

_____

I verify that the above information is true and accurate to the best of my knowledge.

X _____ Date _____

Signature of patient or parent/guardian

Provider Initials _____