Precision Dermatology and Skin Surgery, P.A.

Board Certified in Dermatology
Fellowship Trained in Dermatologic Surgery

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Nickname: _____ SS#: _____ DOB: _____ Sex: M / F

Maiden Name: _____ Marital Status: Married Single Divorced Widowed

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

E-Mail Address: _____ Would you like to receive correspondence by email? Yes / No

Occupation: _____ Height: _____ ft _____ inches Weight: _____ lbs

Primary Care Physician: _____ Phone #: _____ Today's Date: _____

Referring Physician: _____ Phone #: _____

Please provide a copy of your insurance card and picture ID at time of visit to the receptionist to scan.

PHARMACY INFORMATION

Pharmacy Name: _____

Phone #: _____ City or Zip Code: _____

I authorize Precision Dermatology and Skin Surgery to import a list of my current medications from my pharmacy to use as part of my medical record.

Signature: _____

EMERGENCY INFORMATION

Please list emergency contact person:

Name: _____ Relation: _____

Home Phone: (_____) _____ Other Phone: (_____) _____ (Circle) Mobile / Work

Patient (or Legal Guardian) Signature: _____ Date: _____

Print Name: _____

AUTHORIZATIONS

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I authorize payment to my doctor and/or Precision Dermatology and Skin Surgery, P.A. of any health insurance benefits that are payable to me, including but not limited to Medicare payments, "Medigap" payments, and/or payments from private insurance companies. I certify that the information that I gave to my doctors and/or Precision Dermatology and Skin Surgery, P.A. to bill for payment is correct. I assign and transfer to Precision Dermatology and Skin Surgery, P.A., my doctors and/or hospital or their hospital or their agents to the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due. I understand that I have to pay my doctors and/or Precision Dermatology and Skin Surgery, P.A. for all charges not paid by my health insurance. This payment authorization, assignment of benefits, and agreement for financial responsibility is also binding to my administrators, executors, heirs, and successors. Although Precision Dermatology and Skin Surgery, P.A. collects an estimate of patient responsibility at the time of service, I understand Precision Dermatology and Skin Surgery, P.A. will bill me for any additional cost associated with the care given by Precision Dermatology and Skin Surgery, P.A. I have read this assignment of benefits, I understand this assignment of benefits, and my questions have been answered.

Patient / Authorized Party _____ Witness Initial: _____

Print Name: _____

AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS

I understand Precision Dermatology and Skin Surgery, P.A. and/or my doctor is allowed to use and disclose my heath information for treatment, payment, or operations and I understand Precision Dermatology and Skin Surgery, P.A. and/or my doctors to release this information as allowed by law. I understand that when Precision Dermatology and Skin Surgery, P.A. uses and discloses my health information as described in this authorization, the doctor and/or Precision Dermatology and Skin Surgery, P.A. may disclose general information contained within my medical record. I understand that full disclosure of my HIV, drug and alcohol abuse or mental health treatment record will not occur without my specific written consent relating to these conditions. My signature below means I have read this authorization and I understand this authorization to release my health information.

Patient / Authorized Party _____ Witness Initial: _____

Print Name: _____

If Other Than Patient Signing

Name of Person Signing on Behalf of Patient (Print): _____ Relationship: _____

Legal Guardian? Yes / No

If no, the state that permits signing for this patient: _____

(A copy of the authorizing document must be provided for review and inclusion in the patient's medical record)

PLEASE NOTE: There will be a $35 cancellation fee for all appointments re-scheduled less than 24 hours from appointment time.

I am aware of the $35 cancellation / re-schedule fee (SIGNATURE): _____

MEDICAL HISTORY INTAKE FORM

Patients Name (Print): _____ DOB: _____

Past Medical History: (Please check all that apply)

_____ Anxiety
_____ Arthritis
_____ Asthma
_____ Atrial Fibrillation
_____ Bone Marrow Transplantation
_____ Breast Cancer
_____ Colon Cancer
_____ COPD
_____ Coronary Artery Disease
_____ Depression
_____ Diabetes
_____ End Stage Renal Disease
_____ GERD
_____ Hearing Loss
_____ Hepatitis
_____ High Blood Pressure
_____ HIV / AIDS
_____ High Cholesterol
_____ Thyroid Problems
_____ Lung Cancer
_____ Lymphoma
_____ Prostate Cancer
_____ Radiation Treatment
_____ Seizures
_____ Stroke
_____ **NONE**

Other _____

Past Surgical History: (Please check all that apply)

_____ Appendix Removed
_____ Bladder Removed
_____ Mastectomy Circle: Right, Left, Bilateral
_____ Lumpectomy Circle: Right, Left, Bilateral
_____ Breast Biopsy Circle: Right, Left, Bilateral
_____ Colectomy: Colon Cancer Resection
_____ Colectomy: Diverticulitis
_____ Colectomy: IBD
_____ Gallbladder Removed
_____ Coronary Artery Bypass
_____ Mechanical Valve Replacement
_____ Biological Valve Replacement
_____ Heart Transplant
_____ Joint Replacement: Knee Circle: Right, Left, Bilateral
_____ Joint Replacement: Hip Circle: Right, Left, Bilateral
_____ Kidney Biopsy (Nephrectomy)
_____ Kidney Removed Circle: Right, Left
_____ Kidney Stone Removal
_____ Kidney Transplant
_____ Liver Transplant
_____ Ovaries Removed: Endometriosis
_____ Ovaries Removed: Ovarian Cyst
_____ Ovaries Removed: Ovarian Cancer
_____ Prostate Biopsy
_____ TURP (Prostate Removal)
_____ Spleen Removed
_____ Testicles Removed Circle: Right, Left
_____ Hysterectomy: Fibroids
_____ Hysterectomy: Cancer Circle: Uterine, Cervical
_____ **NONE**

Other _____

Family History of Health Problems: (i.e.: diabetes, cancer, high blood pressure, ect. First degree relatives only.)

_____

_____

_____

MEDICAL HISTORY INTAKE FORM PAGE 2

Skin Disease History: (Please check all that apply)

_____ Acne
_____ Actinic Keratosis
_____ Asthma
_____ Basal Cell Carcinoma
_____ Blistering Sunburns
_____ Dry Skin
_____ Eczema
_____ Flaking or Itchy Scalp
_____ Hay Fever / Allergies
_____ Melanoma
_____ Poison Ivy
_____ Precancerous Moles
_____ Psoriasis
_____ Squamous Cell Carcinoma
_____ **NONE**

If you have a history of Melanoma, please include the year, location, depth, and if you had a lymph node biopsy / removal.

Other _____

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 Melanoma? _____ Yes _____ No

If yes, which relative(s)? _____

Medications: (Please include strength and frequency used. If you are not taking any medications, please write NONE)

_____

_____

_____

_____

Allergies: (Please list all medication allergies. If you are not allergic to any medications, please write NONE)

_____

_____

Social History: (Please check all that apply)

Cigarette Smoking:

_____ Currently Smoker
Packs per day _____
_____ Never smoked
_____ Former smoker

Alcohol Use:

_____ None
_____ Less than 1 drink per day
_____ 1-2 drinks per day
_____ 3 or more drinks per day

MEDICAL HISTORY INATAKE FORM PAGE 3

Review of Systems: Are you currently experiencing any of the following? (Please check 'Yes' or 'No)

Symptom	Yes	No
Problems with bleeding	☐	☐
Rash	☐	☐
Problems with healing	☐	☐
Form keloids	☐	☐
Diabetes	☐	☐
Immunosuppression	☐	☐
Chest pain	☐	☐
Fever or chills	☐	☐
Thyroid problems	☐	☐
Joint aches	☐	☐
Muscle weakness	☐	☐
Seizures	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Other Symptoms _____

Alerts: (Please check all that apply)

_____ Allergy to adhesive

_____ Allergy to lidocaine

_____ Artificial joint replacement

_____ Allergy to topical antibiotics

_____ Blood thinners

_____ Defibrillator

_____ MRSA

_____ Pacemaker

_____ Require antibiotics prior to a surgical procedure

_____ Rapid heartbeat with epinephrine

_____ Are you pregnant or currently trying to get pregnant?

Family History of Skin Cancer (Only first degree relatives. This includes your parents, children, brothers, and sisters)

_____

_____