COMPLETE DERMATOLOGY

NEW PATIENT FORMS. Please PRINT

Patient Name:_____ Nickname/AKA:_____

Date of Birth:_____/_____/_____ Sex: M / F Marital Status:_____

Home #:_____ Cell #:_____ Contact Preference: Home / Cell

Occupation: _____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Email Address (for Patient Portal Access):_____@_____

Primary Care Provider:_____ Referring Provider:_____

Emergency Contact/Relationship:_____ Phone Number:_____

Guarantor Name/DOB:_____ Relationship to Patient:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

PRIMARY INSURANCE INFORMATION

Ins Co Name:_____ Policy/Member ID #:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy Holder Sex: M / F Patient Relationship to Insured: Self / Spouse / Child / Other:_____

SECONDARY INSURANCE INFORMATION

Ins Co Name:_____ Policy/Member ID #:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy Holder Sex: M / F Patient Relationship to Insured: Self / Spouse / Child / Other:_____

Military/Veterans: Sponsor's Name, DOB, & SSN are required for Insurance Verification & Payment

COMPLETE DERMATOLOGY

Today's Date:___/____/_____ Name:_____ Birth Date:_____/_____/_____

Medical History Questionnaire

The reason for today's visit: _____

Present for how long?_____

Personal Dermatological History ***Please check if you have a history of:**

☐Skin Cancer

Which Type?

☐Melanoma- When? _____ Body Location?_____

☐Basal Cell Cancer- When? _____ Body Location? _____

☐Squamous Cell Cancer- When? _____ Body Location?_____

☐Actinic Keratosis (Precancerous Skin Growth)

☐Eczema ☐Psoriasis ☐Lupus ☐Scarring Acne

☐Other Dermatologic Condition(s)_____

☐ NONE

Medical History ***Please check if you have a history of:**

☐Allergies/Sinusitis
☐Artificial Heart Valve
☐Asthma
☐Bleeding Disorder
☐Cancer (Other than skin cancer)
Which type?_____
☐Cataracts
☐Cold Sores (Herpetic Infection)
☐Congestive Heart Failure
☐Depression
☐Diabetes
☐Pacemaker
☐Diabetes Mellitus
☐Emphysema/COPD
☐Epilepsy
☐GERD/(Reflux Disease)
☐Glaucoma
☐Heart Arrhythmia
☐Heart Disease
☐Hepatitis
☐High Cholesterol
☐HIV or Aids
☐Hypertension
☐Defibrillator
☐Irritable Bowel Syndrome
☐Mitral Valve Prolapse
☐Organ Transplant
☐Osteoarthritis
☐Osteoporosis
☐Rheumatic Fever
☐Rheumatoid Arthritis
☐Stomach Ulcer
☐Thyroid Disease
☐Tuberculosis
☐Other_____
☐ NONE

For Women:

Are you currently pregnant OR actively trying to get pregnant OR breastfeeding? ☐Yes ☐No

Social History

Do you wear sunscreen regularly? ☐Yes ☐No Use tanning beds? ☐ Yes ☐No

Do you smoke? ☐Yes ☐ No Drink alcohol? ☐Yes ☐ No Use drugs? ☐Yes ☐No

Family History ***Do any family members suffer from the following?** **☐ if NONE**

Condition	Family Member (Relationship)
Skin Cancer (Other than Melanoma)	
Melanoma	
Asthma/Eczema/Seasonal Allergies	
Psoriasis	

ALLERGY LIST

MEDICATION/FOOD ALLERGIES	REACTION

**Any allergy to: (Please Check)

Adhesive	☐Yes	☐No	Lidocaine	☐Yes	☐No
Epinephrine	☐Yes	☐No	Latex	☐Yes	☐No
Antibiotic Ointment	☐Yes	☐No			

Please Initial for No Known Drug Allergies: _____

CURRENT MEDICATIONS/SUPPLEMENTS

MEDICATION NAME	MEDICATION STRENGTH	DOSE (How Many)	DOSE FORM (tablet, capsule, etc)	MEDICATION FREQUENCY (How many Times per day)

Please Initial for No Current Medications: _____

I hereby certify that the above information is true and accurate, to the best of my knowledge.

_____ _____ _____

Patient/ Guardian Signature Patient/ Guardian Print Name Date

Relationship if other than patient:_____

Complete Dermatology Financial Policies, Privacy Practices, & HIPAA

I hereby certify that I have been provided with the **Complete Dermatology Financial Policy**, that I have had the opportunity to review its policies, and agree to abide by the terms set forth in the document.

I acknowledge that Complete Dermatology has made the **Notice of Privacy Practices** available to me. I authorize release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorized payment of medical benefits to the physicians.

In general, the **HIPAA privacy rule** gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that communication or PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving lab or procedure results with a designated person.

Unless a fax machine is a secure area, Protected Health Information (PHI) can not be faxed.

I wish to be contacted in the following manner.

Best Phone number:_____

- ☐Leave a message with a call back number
- ☐Leave medical information with my spouse, parent, family member, other _____
- ☐Do not leave a message
- ☐Leave a message with detailed information
- ☐Authorization to discuss medical information with:_____
  (Please print authorized person(s) name/relationship.))
- ☐Text message (When Available)
- ☐Email (When Available)

This Consent will remain in effect unless otherwise revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date

Relationship if other than patient:_____