PATIENT INFORMATION

Name: _____ **Date**: _____

Address:_____ **City**:_____ **ZIP**:_____ **State**:_____

DOB:_____ **Phone Number**:_____ **Marital Status**:_____

Occupation:_____**Work Number**:_____

Circle: Female or Male **Emergency Contact**:_____**Phone Number**:_____

Primary Insurance:_____**Subscriber's Name**: _____**DOB**:_____

Secondary Insurance:_____**Subscriber's Name**:_____**DOB**:_____

Email:_____

Referred by:_____**Family Doctor**:_____

Reason for your visit today:_____

Parent Information (PRESENT WITH CHILD)

Name:_____**DOB**:_____**Phone**:_____

Address:_____

Preferred Pharmacy (Name, City and Cross Streets):_____

MEDICAL HISTORY

Please list any Allergies you have to medications (tape adhesive, latex, etc.):_____

_____

Please list all medications you are currently taking: (you can also provide a list)

_____

_____

Are you taking any blood thinners? YES / NO (Aspirin/Coumadin/Plavix)

Your Personal History (ROS): (Current or History of)

Please circle "Yes" or "No" to the following, as it pertains to you:

Yes/No	Anxiety	Yes/No	Hearing loss
Yes/No	Arthritis	Yes/No	Hepatitis
Yes/No	Artificial Joints	Yes/No	Hypertension (Blood Pressure)
Yes/No	Asthma	Yes/No	HIV/AIDS
Yes/No	Atrial Fibrillation	Yes/No	Hypercholesterolemia (High Cholesterol)
Yes/No	BPH (Enlarged Prostate)	Yes/No	Thyroidism (Hyper or Hypo)
Yes/No	Bone Marrow Transplant	Yes/No	Leukemia
Yes/No	Breast Cancer	Yes/No	Lymphoma
Yes/No	Colon Cancer	Yes/No	Lung Cancer
Yes/No	COPD (Lung Disease)	Yes/No	Pacemaker
Yes/No	Coronary Artery Disease	Yes/No	Prostate Cancer
Yes/No	Depression	Yes/No	Radiation Treatment
Yes/No	Diabetes	Yes/No	Seizures
Yes/No	Renal Disease	Yes/No	Stroke
Yes/No	GERD (Acid Reflux)	Yes/No	Valve Replacement

Skin Disease History: (Current or if you've had a history of)

Please circle "Yes" or "No" to the following, as it pertains to you:

Yes/No Acne
Yes/No Actinic Keratoses
Yes/No Alopecia
Yes/No Warts
Yes/No Blistering Sunburn
Yes/No Dry Skin
Yes/No Eczema
Yes/No Flaking or itchy scalp
Yes/No Hay Fever/Allergies
Yes/No Herpes Simplex (Cold Sores)
Yes/No Melanoma
Yes/No Poison Ivy
Yes/No Psoriasis
Yes/No Rosacea
Yes/No Shingles
Yes/No Squamous Cell and/or Basal Cell

Family History of Melanoma: YES / NO
other:_____
If yes, which relative(s)_____

Any other serious illness or major surgeries/procedures?
_____

Habits: Tobacco use: Yes / No / Occasional
Alcohol use: Yes / No / Occasional

For Females:
Are you pregnant? YES / NO If yes, Due date_____
Planning a pregnancy? YES / NO
Nursing? YES / NO

Authorization To Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. **I also request payment of benefits to my provider, Middlebelt Dermatology Center. I also understand I am responsible for any co-pays, deductibles and any non-covered services. I am responsible for my referral and payment is due at the time of service.** I understand if I can't attend any scheduled appointments, I will notify Middlebelt Dermatology Center within 24 hours in advance. If I fail to provide a 24 hour notice, I am responsible for a **NO SHOW FEE IN THE AMOUNT OF $25.00**.

Authorization To Release Medical Information:
I hereby authorize my Provider, Middlebelt Dermatology Center to release any information necessary for my course of treatment. I authorize my provider to leave detailed voice mail messages at the Following Phone Number(s)

_____
(voice mail includes any information, unless listed here):

HIPPA:
The notice was posted in a clear location where I was able to read it and / or received a copy,
I authorize Name:_____Relationship:_____
to receive all medical information.

_____ Date:_____
Sign and Date