



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

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

Is visit related to an accident? Yes / No If yes, specify: _____ Work Comp: Yes / No

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: _____

EMERGENCY INFORMATION

Please list emergency contact person:

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

REFERRAL INFORMATION

Name of person/office who referred you (if applicable): _____

Other (Circle): Newspaper / Yellow Pages / Internet / Other: _____

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 health 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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV / AIDS | |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> NONE |

Other _____

Past Surgical History: (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Biopsy (Nephrectomy) |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Kidney Removed Circle: Right, Left |
| <input type="checkbox"/> Mastectomy Circle: Right, Left, Bilateral | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Lumpectomy Circle: Right, Left, Bilateral | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Breast Biopsy Circle: Right, Left, Bilateral | <input type="checkbox"/> Liver Transplant |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Ovaries Removed: Endometriosis |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Ovaries Removed: Ovarian Cyst |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> TURP (Prostate Removal) |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Testicles Removed Circle: Right, Left |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Hysterectomy: Fibroids |
| <input type="checkbox"/> Joint Replacement: Knee Circle: Right, Left, Bilateral | <input type="checkbox"/> Hysterectomy: Cancer Circle: Uterine, Cervical |
| <input type="checkbox"/> Joint Replacement: Hip Circle: Right, Left, Bilateral | |
| | <input type="checkbox"/> 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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Hay Fever / Allergies | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | |
| | | <input type="checkbox"/> 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

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

Symptom	Yes	No
Problems with bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>
Form keloids	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Joint aches	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>

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)
