

BROWNSBORO DERMATOLOGY

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(PLEASE PRINT)

PATIENT NAME _____ NICKNAME or
PREFERRED NAME _____

ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____

CITY _____ ST _____ ZIP _____ CELL PHONE _____

AGE _____ DATE OF BIRTH _____

EMPLOYED YES [] NO [] MALE [] FEMALE []

EMPLOYER _____ MARITAL STATUS _____

EMERGENCY CONTACT _____ EMERGENCY CONTACT PHONE _____

REFERRING DOCTOR _____ FAMILY DOCTOR _____

RESPONSIBLE PARTY (receives statement)

NAME _____ PHONE # _____ WORK # _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

RELATIONSHIP _____

POLICY HOLDER (carries insurance)

SUBSCRIBER (PERSON) _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ RELATIONSHIP _____

INSURANCE NAME _____

GROUP # _____

POLICY HOLDER ID# _____ EMPLOYER _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I AUTHORIZE BROWNSBORO DERMATOLOGY TO RELEASE INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR MEDICAL SERVICES. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO BROWNSBORO DERMATOLOGY FOR SERVICES RENDERED AND AGREE TO PAY ANY CHARGES NOT COVERED BY MY INSURANCE. A SERVICE CHARGE MAY BE APPLIED TO AN OUTSTANDING ACCOUNT THAT HAS BEEN BILLED FOR 90 DAYS. I ALSO UNDERSTAND THAT IF MY INSURANCE COMPANY REQUIRES A REFERRAL, IT IS MY RESPONSIBILITY TO OBTAIN ONE. IF I FAIL TO DO SO, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED. IF THE PATIENT IS A MINOR, I GIVE PERMISSION FOR MY CHILD TO BE TREATED.

PATIENT'S SIGNATURE _____ Date _____

PARENT/GUARDIAN SIGNATURE _____ Date _____

PATIENT NAME _____ DATE OF BIRTH _____

We request that you provide us with your updated medical history. We rely on this information when making medical decisions regarding your care. Thank you for taking your time to complete this information.

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MEDICAL HISTORY

Current Medications _____
(PRESCRIPTION AND OVER THE COUNTER DRUGS)

Drug Allergies or reactions _____

PAST MEDICAL HISTORY
(Please check the box if you have ever had...)

| | | | |
|------------------------|----------------|---------------------|-------------------------|
| Anemia | Diabetes | High Blood Pressure | Skin Cancer |
| Arthritis | Emphysema | HIV | Stroke |
| Asthma | Hay fever | Kidney Disease | TB |
| Bleeding Disorder | Heart Disease | Osteoporosis | Thyroid Disease |
| Cancer _____ (type) | Hepatitis | Rheumatic Fever | Ulcers |
| Chronic Bronchitis | Fever Blisters | Seizures | Pacemaker/Defibrillator |
| High Cholesterol | Other _____ | | |

Previous Surgeries _____

Are you pregnant or planning a pregnancy? () YES () NO

Has anyone in your immediate family (parent, sister, brother or your child) had any of the following?

_____ Skin Cancer _____ Melanoma _____ Unusual Moles

Do you smoke? () YES () NO Do you use alcohol? () YES () NO

Do you use tanning beds? () YES () NO

We recommend a baseline skin exam for all adults to screen for skin cancer and melanoma. We encourage you to schedule this complete exam soon. This exam may take place yearly or as frequently as your physician deems necessary.

TODAY'S DATE _____