Brownsboro Dermatology, PLLC
4938 Brownsboro Road, Suite 206, Louisville, KY 40222
502-339-2922 Phone, 502-339-2912 Fax
Laura R. Klein, MD * Denise L. Puthuff, MD * Patricia S. Todd, MD * Michelle H. Hannigan, APRN

***Section I. PATIENT INFORMATION:

NAME: _____ NAME YOU WANT TO BE CALLED: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

BEST PHONE NUMBER TO REACH YOU: _____ ALTERNATE PHONE: _____

DOB: _____ MARITAL STATUS: _____ EMPLOYER: _____

GENDER: _____ EMAIL: _____ PRIMARY CARE MD: _____

***Section II. EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER (MUST BE DIFFERENT FROM PATIENT PHONE NUMBER): _____

***Section III. INSURANCE POLICYHOLDER INFORMATION (IF NOT PATIENT):

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

DOB: _____ PHONE NUMBER: _____

***Section IV. PRIMARY INSURANCE INFORMATION:

INSURANCE NAME: _____ GROUP #: _____ ID#: _____

**IF YOU ARE RETIRED, DO YOU HAVE SECONDARY INSURANCE? IF YES, PLEASE ENTER INFORMATION BELOW:

INSURANCE NAME: _____ GROUP #: _____ ID#: _____

***Section V. AUTHORIZATION:

I authorize Brownsboro Dermatology, PLLC, to release information necessary to process insurance claims for medical services. I authorize payment of insurance benefits to Brownsboro Dermatology, PLLC, for services rendered and agree to pay any charges not covered by my insurance. I verify that the insurance with Brownsboro Dermatology, PLLC, is the correct insurance in effect on this date. I understand that I am completely responsible for any cosmetic procedures. 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 the child to be treated.

_____ _____

SIGNATURE (DO NOT PRINT) DATE

Adult History Form (Ages 18 and Over)

Patient Name: _____ Date: _____

Date of Birth: _____

Check Yes or No if you now have
OR have ever had any of following:

Yes	No		
☐	☐	Anemia	
☐	☐	Bleeding Disorder ☐	and/or Blood Clots ☐
☐	☐	Stroke/TIA's	
☐	☐	Seizures	
☐	☐	Rheumatoid Arthritis	
☐	☐	Psoriatic Arthritis	
☐	☐	Osteoarthritis ☐	Other Arthritis _____
☐	☐	Diabetes	
☐	☐	Asthma ☐	and/or Hay Fever/Seasonal Allergies ☐
☐	☐	Emphysema/COPD	and/or Chronic Bronchitis ☐
☐	☐	Thyroid Disease	
☐	☐	Lupus	
☐	☐	Stomach Ulcers ☐	and/or GERD ☐
☐	☐	Inflammatory Bowel Disease:	
☐	☐	Cancer	Type: _____
☐	☐	Fever Blisters	
☐	☐	Depression ☐	Anxiety ☐ ADHD ☐
☐	☐	Genital Herpes	
☐	☐	High Blood Pressure	
☐	☐	Elevated Cholesterol/Lipid Levels	
☐	☐	Heart Disease:	Stent Placement ☐
☐	☐	Pacemaker/Defibrillator	
☐	☐	Heart Valve Problems/Heart Murmurs	
☐	☐	Kidney Disease	
☐	☐	Liver Disease	
☐	☐	Hepatitis:	
☐	☐	HIV ☐	and/or Exposure to HIV ☐
☐	☐	Tuberculosis (TB) ☐	and/or Positive PPD Skin Test ☐

Other Diseases:

Drug Allergies: No known Drug Allergies ☐

_____

_____

Pharmacy Name & Location: _____

_____

_____

Pharmacy Phone Number: _____

List of Medications:
Including over-the-counter medications
OR you may attach a list.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Social History:
Have you ever smoked? ___Yes ___No
Still smoke ☐ Quit ☐ # years: ☐
Do you use alcohol? ___Yes ___No
Have you ever used a tanning bed? ___Yes ___No

Previous Surgeries: No previous Surgeries: ☐

_____

_____

_____

_____

Yes	No	**Women of Childbearing Age Only:**	
☐	☐	Are you pregnant or breastfeeding?	Due Date:
☐	☐	Are you planning a pregnancy?	

****History of Skin Cancers:**

☐ No personal history of skin cancer.
☐ No family history of skin cancer.

	Self:	Family Member:
Melanoma	☐	_____
Skin Cancers: Basal Cell	☐	_____
Skin Cancers: Squamous Cell	☐	_____
Unusual/Atypical Moles	☐	_____

To be completed by Office: Skin Cancers

Date	Diagnosis	Location:

Pediatric History Form (Ages 17 and Under)

Patient Name: _____ Date: _____

Date of Birth: _____

PAST MEDICAL HISTORY

Check Yes or No if you now have
OR have ever had any of the following:

Yes	No	
☐	☐	Allergic Rhinitis
☐	☐	Asthma
☐	☐	ADHD
☐	☐	Diabetes
☐	☐	Developmental Delay
☐	☐	Heart Disease
☐	☐	Cancer Specify:
☐	☐	Autoimmune Disease Specify:
☐	☐	Immune System Disease Specify:

Does your child have any other medical problems?

_____

_____

Has your child had any surgeries? Please describe:

_____

_____

Has your child been hospitalized? Please describe:

_____

_____

SOCIAL HISTORY

The patient lives with (circle):
☐ mother ☐ father ☐ parents
other: _____

Other caregivers: _____

Please list the patient's daycare/school and grade:

_____

BIRTH HISTORY

Born at: ____ ☐ Term ____ ☐ Premature
Any complications? _____

_____

DRUG ALLERGIES

☐ No Known Drug Allergies

Medication	Reaction

PHARMACY NAME, LOCATION, AND PHONE NUMBER

MEDICATIONS

FAMILY HISTORY

Please enter if any of the following has occurred in a family member:

	What is the relation to the patient? (e.g., brother, maternal grandparent)
Eczema	
Asthma	
Allergies	
Psoriasis	
Alopecia	
Autoimmune Disease	
Melanoma	

Please list patient's siblings and their ages:

_____

_____