



Illinois Dermatology Institute

PATIENT INFORMATION

(Please Print)

Today's Date ____/____/____

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone () _____ Work Phone () _____ Cell Phone () _____
OK to leave message: Yes No OK to leave message: Yes No OK to leave message: Yes No

Date of Birth: ____/____/____ S.S.# ____/____/____ Marital Status: _____ Spouse Name: _____

Age: _____ Sex: _____ Race: _____ Employment: FT PT FT-Student PT-Student Retired Unemployed

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Date of Birth: ____/____/____ S.S.# ____/____/____ Age: _____ Sex: _____ Relation: _____

INSURANCE INFORMATION (After you have finished completing this form, please bring it to the front desk along with your current insurance card and photo ID)

Primary Insurance Co. Name _____
Name of Insured _____
Address of Insured (if different) _____
Date of Birth of Insured _____
Employer Name _____
Relationship of patient to Insured _____

Secondary Insurance Co. Name _____
Name of Insured _____
Address of Insured (if different) _____
Date of Birth of Insured _____
Employer Name _____
Relationship of patient to Insured _____

Do you have prescription coverage? Yes No

In case of Emergency, who should be notified? _____ Phone () _____

Can we discuss your medical conditions with other members of your household? Yes No Specify _____

Referred by: Physician _____ Family/Friend _____

How did you hear about us? Friend/Family Internet Advertisement Insurance Referral Yellow Pages Physician Other _____

I authorize the 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 authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected. **We accept payment in the form of cash or credit card.** If we do accept a check for payment, and the check does not clear the bank, a \$25.00 service fee will be automatically added to your account. In the event that your account must be turned over to collections, a 25% collection fee will be added to your account. **Please note that any procedure performed in the office may be billed separately and in addition to the office visit fee.** Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ____/____/____

If patient is a minor, Print name of responsible party _____ Relationship _____

Illinois Dermatology Institute

Medical History

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? Yes No **If yes, Please list:** _____

Have you ever had dental anesthesia (Novocain)? Yes No Any bad reactions? Yes No

List all medication you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Currently not taking ANY medications:

Do you have now, or have you ever had diseases or conditions of:

LUNGS: YES NO

Emphysema YES NO

Asthma YES NO

CARDIOVASCULAR:

High Blood Pressure YES NO

High Cholesterol YES NO

Heart Attack YES NO

History of blood clots YES NO

Pacemaker YES NO

Defibrillator YES NO

Heart Valve YES NO

Stents YES NO

OTHER SYSTEMIC: YES NO

Diabetes YES NO

Kidney Dialysis YES NO

Thyroid YES NO

Hepatitis B YES NO

Hepatitis C YES NO

Glaucoma YES NO

Joint Replacement YES NO

Organ Transplants YES NO

Nausea, Vomiting, Diarrhea

when taking antibiotics? YES NO

Fainting YES NO

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

SKIN: Do you use tanning salons? Yes No How often? _____

Have you ever had skin cancer? Yes No

Has anyone in your family had skin cancer? Yes No

Do you have a history of any specific skin diseases? Yes No If Yes, _____

Do you have problems with healing? Yes No

Do you develop keloids (scars) after surgery? Yes No

Do you bleed easily? Yes No

Do you develop skin rashes in reaction to: Medication Food Environment Bandages Topical Neosporin Other _____

Social History:

Do you drink alcohol? Yes No _____ drinks per day.

Do you use IV drugs? Yes No

Do you smoke? Yes No How much? _____

Do you have or have you been exposed to HIV (AIDS)? Yes No

Occupation: _____

Primary Doctor _____

Address: _____

Phone # () _____

Female Patients Currently: Pregnant? Yes No Due Date _____ Breast Feeding? Yes No Trying to get pregnant? Yes No

Completed by: Patient Parent/Guardian Other _____

Medical Assistant _____ (initials)

_____/_____/_____

Patient/Parent/Guardian Signature Date

Reviewed by: _____/_____/_____

Date