

PATIENT UPDATE INFORMATION FORM (if you have not been in the office in the past year)

PATIENT INFORMATION

(Please Print)

Today's Date ____/____/____

Name _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone () _____ Cell Phone () _____ S.S. # _____

Date of Birth ____/____/____ Age ____ Sex ____ Marital Status _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone () _____ Cell Phone () _____ S.S. # _____

Date of Birth ____/____/____ Sex ____

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

Primary Insurance Name _____

Name of Insured _____

Insured's SS # _____

Insured's ID # _____

Group # _____

Employer Name _____

Employer Phone () _____

Relationship of patient to Insured _____

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

Secondary Insurance Name _____

Name of Insured _____

Insured's SS # _____

Insured's ID # _____

Group # _____

Employer Name _____

Employer Phone () _____

Relationship of patient to Insured _____

Do you have prescription coverage (Prescription/Rx Card)? _____

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 they 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 a prepaid plan in which we participate. For those patients, applicable copayments will be collected. We accept payment in the form of cash, check (under \$100), or credit card. In the event that your account must be turned over to collections, a 25% collection fee will be added to your account. 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 _____

DERMATOLOGY MEDICAL HISTORY

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

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

Have you ever had dental anesthesia (Novocaine)? Yes _____ No _____ Any bad reaction? Yes _____ No _____

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

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

LUNGS:

	YES	NO
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR:

High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stents	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
History of blood clots	<input type="checkbox"/>	<input type="checkbox"/>

PACEMAKER

Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
---------------	--------------------------	--------------------------

OTHER SYSTEMIC:

	YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Knee Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Organ Transplants	<input type="checkbox"/>	<input type="checkbox"/>

Female Patients:

Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Breast feeding	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

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

SKIN: Have you ever had skin cancer?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Has anyone in your family had skin cancer?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Do you have a history of any specific skin diseases?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	If yes, _____
Do you have problems with healing?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Do you develop keloids (scars) after surgery?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Do you bleed easily?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	

Primary Doctor: _____

Address: _____

City: _____ Zip: _____ Phone: () _____

Cardiologist: _____

Address: _____

City: _____ Zip: _____ Phone: () _____