Account # _____

PATIENT INFORMATION FORM

Last Name: _____ First Name: _____Middle Name: _____

Date of Birth: _____ Social Security #: _____ Sex: M / F / MTF / FTM Other _____

Race: ☐ **Asian** ☐ **Black** ☐ **Hispanic** ☐ **White** ☐ **Patient Refused**
Ethnicity: ☐ **Latino** ☐ **Non-Latino** ☐ **Patient Refused**
Language: ☐ **English** ☐ **Spanish** ☐ **Sign Language** ☐ **Other** ☐ **Patient Refused**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Other**

Street Address: _____ APT #: _____

City: _____ State: _____ Zip Code: _____

Phone #:_____ Cell #:_____ Work #:_____

Email address: _____

Family Physician: _____ Town:_____

Do you have medical insurance? ☐ **Yes** ☐ **No**

If patient is a minor, are parents: ☐ **Married** ☐ **Separated** ☐ **Divorced**

Primary Insurance **_____ Policy Number _____**

Subscriber's Name _____ Group Number _____

Subscriber's DOB _____ Subscriber's SS# _____

Relationship to Subscriber: SELF SPOUSE CHILD OTHER

Secondary Insurance **_____ Policy Number _____**

Subscriber's Name _____ Group Number _____

Subscriber's DOB _____ Subscriber's SS# _____

Relationship to subscriber: SELF SPOUSE CHILD OTHER

Managed care/PPO/HMO/POS or Medicare patients: I assume responsibility for any service that is not approved on my referral (if such form is required by my plan); any service which is either cosmetic in nature and/or not covered by my insurer; any visit for which I have not presented a required referral form on the day of service or is ultimately not covered by my insurance plan. I assign payment benefits for my primary, secondary and/or Medigap plan to this provider. I am responsible for paying for all the non-covered and/or cosmetic services on the day they are provided to me. I understand that I am responsible for any DEDUCTIBLE, COPAY OR COINSURANCE designated by my plan as being my responsibility. I do hereby agree to pay to Affiliated Dermatologists and Dermatologic Surgeons, P.A. and/or Affiliated Ambulatory Surgery, P.C., the full amount of any and all bills for services rendered to the above-named patient not covered by my insurance into which the physicians may have entered into an agreement. I hereby authorize the release of information necessary to file a claim with my insurer, and/or which is pertinent to my case to any insurance company involved in my care. A copy of this signature is valid as the original. If applicable: I hereby authorize you to evaluate and treat the above named minor child today and all future visits. If patient is a minor: I am attesting that I have legal custody of my minor child.

X_____ Today's Date:_____
SIGNATURE OF PATIENT OR PATIENT'S GUARDIAN REQUIRED

PLEASE FILL OUT REVERSE SIDE OF FORM

MEDICAL INFORMATION

List any allergies (drugs, foods, latex, band aids, adhesive or antibiotic ointments) _____

_____

Do you have a Pacemaker, Defibrillator, Neurostimulator or any implantable device? _____

_____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Lung Disease	□	□	Diabetes	□	□
Asthma	□	□	Thyroid	□	□
Artificial Joints	□	□	Kidney	□	□
High Blood Pressure	□	□	Bladder	□	□
Heart Problems	□	□	Gastrointestinal Disease	□	□
Fainting	□	□	Convulsions, Epilepsy or Seizures	□	□
Hepatitis/Liver disease	□	□	**Social History**		
Blood Clots	□	□	Daily Alcohol Use?	□	□
Cancer	□	□	Smoker?	□	□

List any significant past or current medical conditions and/or surgeries: _____

_____

_____

Skin:

Personal history of Psoriasis or Eczema? □ YES □ NO
Personal history of bleeding disorder? □ YES □ NO
Personal history of skin cancer (including melanoma)? □ YES □ NO
Family history of skin cancer(including melanoma)? □ YES □ NO
Any other skin conditions? □ YES □ NO If Yes, what type_____

List any medications you are currently taking.

Medication	
1.	**7.**
2.	**8**
3.	**9.**
4.	**10.**
5.	**11.**
6.	**12.**

Females: Are you pregnant or breast feeding? ☐ YES ☐ NO ☐ NOT APPLICABLE

Purpose of today's visit: _____