# DERMATOLOGY CLINIC

## (A Professional Medical Corporation)

**PATIENT INFORMATION** **(Please Print)** **Today's Date:** _____

Name: _____ Email: _____
**Last** **First** **M.I.**
Mailing Address: _____
**City** **State** **Zip**
Sex: ___ Marital Status: ___ Date of Birth: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
SS#: _____ Occupation: _____

**PARENT OR RESPONSIBLE PARTY (If different from patient)**

Name: _____ Email: _____
**Last** **First** **M.I.**
Mailing Address: _____
**City** **State** **Zip**
Sex: ___ Marital Status: ___ Date of Birth: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
SS#: _____

**INSURANCE INFORMATION (Please present current insurance card at time of check in)**

Name: _____ Email: _____
**Last** **First** **M.I.**
Mailing Address: _____
**City** **State** **Zip**
Sex: ___ Marital Status: ___ Date of Birth: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
SS#: _____ Occupation: _____

**Primary** Insurance Name: _____
Ins. Address: _____
Name of Insured: _____
Insured's ID#: _____
Group#: _____
Employer Name: _____
Relationship of the patient to the insured _____

**Secondary** Insurance Name: _____
Ins. Address: _____
Name of Insured: _____
Insured's ID#: _____
Group#: _____
Employer Name: _____
Relationship of the patient to the insured _____

Other Family Members that are patients: _____
Pharmacy of Choice: _____
In case of emergency, who should be notified? _____

Referring Doctor: _____
First Last Telephone
Primary Care Physician: _____

*I authorize the release of medical information to my primary care or referring physicians, 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.*

Patient or Responsible Party Signature: _____ Date: _____

Updated by: _____

Do you currently use tobacco products? ☐ Yes ☐ No If yes, what type of tobacco?_____

Drug Allergies_____

Medications_____

| Patient Past Medical History | Yes | Details |
|---|---|---|
| | | |
| Hayfever, Asthma, Sinus | | |
| Cancer | | |
| Diabetes | | |
| Heart Disease, Lung Disease | | |
| Hepatitis | | |
| High Blood Pressure | | |
| Kidney Disease | | |
| Skin Cancer | | |
| Skin Disorders | | |
| Thyroid Disease | | |
| Tuberculosis | | |
| Stomach Ulcers | | |
| Are you Pregnant | | |
| Anemia | | |
| Chemotherapy | | |
| HIV | | |
| Anesthesia Allergies | | |

**Past Surgeries/Hospitalizations**

| Date & Type of Surgery | Anesthesia Complications Y/N | Details |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Patient Family History | Yes | Affected Family Member |
|---|---|---|
| | | |
| Anesthesia Problems | | |
| Autoimmune Problems | | |
| Cancer | | |
| Diabetes | | |
| Drug Allergies | | |
| Endocrine Disease | | |
| Heart Disease | | |
| High Blood Pressure | | |
| Kidney Disease | | |
| Liver Disease | | |
| Skin Cancer | | |
| Skin Disease | | |

Email Address:_____