Precision Dermatology and Skin Surgery, PA

Board Certified in Dermatology
Fellowship trained in Dermatologic Surgery

PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)	NICKNAME	DATE OF BIRTH

SOCIAL SECURITY #	SEX	MARITAL STATUS
	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY ADDRESS	APARTMENT/UNIT

CITY	STATE	ZIP

CELL PHONE	HOME PHONE	EMAIL ADDRESS

RACE
☐ Asian
☐ Black or African American
☐ Hispanic
☐ Multi-racial
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other
☐ Declined to Specify

ETHNICITY
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Declined to Specify

RESPONSIBLE PARTY INFORMATION (FOR MINOR OR LEGAL GUARDIANS ONLY)

RESPONSIBLE PARTY NAME	RELATIONSHIP TO PATIENT

CELL PHONE	HOME PHONE

POWER OF ATTORNEY (IF YES, PLEASE PROVIDE PAPERWORK)
☐ Yes ☐ No

ADDITIONAL HEALTHCARE INFORMATION

PRIMARY CARE PHYSICIAN	PRIMARY CARE PHONE NUMBER

PHARMACY NAME	PHARMACY PHONE NUMBER

☐ I AUTHORIZE PRECISION DERMATOLOGY AND SKIN SURGERY TO IMPORT A LIST OF MY CURRENT MEDICATIONS FROM MY PHARMACY TO USE AS PART OF MY MEDICAL RECORDS

ADVANCED CARE PLAN

DO YOU HAVE A HEALTHCARE PROXY IN THE EVENT YOU ARE UNABLE TO MAKE YOUR OWN MEDICAL DECISIONS?
☐ Yes ☐ NO

DESIGNEE'S NAME	PHONE NUMBER

EMERGENCY INFORMATION

EMERGENCY CONTACT NAME	RELATION	PHONE NUMBER

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____ DATE: _____

AUTHORIZATIONS

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I authorize payment to my doctor and/or Precision Dermatology and Skin Surgery, P.A. of any health insurance benefits that are payable to me, including but not limited to Medicare payments, "Medigap" payments, and/or payments from private insurance companies. I certify that the information that I gave to my doctors and/or Precision Dermatology and Skin Surgery, P.A. to bill for payment is correct. I assign and transfer to Precision Dermatology and Skin Surgery, P.A., my doctors and/or hospital or their hospital or their agents to the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due. I understand that I must pay my doctors and/or Precision Dermatology and Skin Surgery, P.A. for all charges not paid by my health insurance. This payment authorization, assignment of benefits, and agreement for financial responsibility is also binding to my administrators, executors, heirs, and successors. Although Precision Dermatology and Skin Surgery, P.A. collects an estimate of patient responsibility at the time of service, I understand Precision Dermatology and Skin Surgery, P.A. will bill me for any additional cost associated with the care given by Precision Dermatology and Skin Surgery, P.A. I have read this assignment of benefits, I understand this assignment of benefits, and my questions have been answered.

Patient / Authorized Party Signature: _____

Name: _____ Witness Initial: _____

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I understand Precision Dermatology and Skin Surgery, P.A. and/or my doctor is allowed to use and disclose my health information for treatment, payment, or operations and I understand Precision Dermatology and Skin Surgery, P.A. and/or my doctors to release this information as allowed by law. I understand that when Precision Dermatology and Skin Surgery, P.A. uses and discloses my health information as described in this authorization, the doctor and/or Precision Dermatology and Skin Surgery, P.A. may disclose general information contained within my medical record. I understand that full disclosure of my HIV, drug and alcohol abuse or mental health treatment record will not occur without my specific written consent relating to these conditions. My signature below means I have read this authorization, and I understand this authorization to release my health information.

Patient / Authorized Party Signature: _____

Name: _____ Witness Initial: _____

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____ DATE: _____

PATIENT MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer: Breast
- ☐ Cancer: Colon
- ☐ Cancer: Leukemia
- ☐ Cancer: Lung
- ☐ Cancer: Lymphoma
- ☐ Cancer: Prostate
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**

Other: _____

_____

PAST SURGICAL HISTORY

- ☐ Appendix Removed
- ☐ Biological Valve Replacement
- ☐ Biopsy: Breast
  Circle: Right, Left Bilateral
- ☐ Biopsy: Prostate
- ☐ Colectomy
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Hysterectomy
- ☐ Joint Replacement: Knee
  Circle: Right, Left, Bilateral
- ☐ Joint Replacement: Hip
  Circle: Right, Left, Bilateral
- ☐ Lumpectomy: Breast
  Circle: Right, Left, Bilateral
- ☐ Mastectomy
  Circle: Right, Left
- ☐ Mechanical Valve Replacement
- ☐ Transplant: Heart
- ☐ Transplant: Kidney
- ☐ Transplant: Liver
- ☐ Removal: Kidney
  Circle: Right, Left
- ☐ Removal: Ovaries
  Circle: Right, Left
- ☐ Removal: Prostate
- ☐ Removal: Spleen
- ☐ Removal: Testicles
  Circle: Right, Left
- ☐ **NONE**

Other: _____

_____

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____ DATE: _____

SKIN DISEASE HISTORY

☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratosis	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Basal Cell Carcinoma	☐ Hay Fever / Allergies	☐ Squamous Cell Carcinoma
☐ Blistering Sunburns	☐ Melanoma	

If you have a history of melanoma, please include any pertinent treatment information on the lines below.

Other: _____

_____

_____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐ No

SKIN CANCER FAMILY HISTORY

Do you have a FAMILY history of melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____
Family history of Other Skin Cancer (Only first-degree relatives. This includes parents, children, brothers, and sisters)

_____

_____

MEDICATIONS

PLEASE INCLUDE STRENGTH AND FREQUENCY USED. IF YOU ARE NOT TAKING ANY MEDICATIONS, PLEASE WRITE **NONE**

_____

_____

_____

_____

_____

ALLERGIES

PLEASE LIST ALL MEDICAL ALLERGIES. IF YOU ARE NOT ALLERGIC TO ANY MEDICATIONS, PLEASE WRITE **NONE**

_____

_____

_____

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____ DATE: _____

SOCIAL HISTORY

CHECK ALL THAT APPLY

Cigarette Smoking:
- ☐ Current Smoker
  Packs per day _____
- ☐ Never smoked
- ☐ Former smoker

Alcohol Use:
- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

REVIEW OF SYSTEMS

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

SYMPTOM	YES	NO
Problems with bleeding	☐	☐
Problems with healing	☐	☐
Form keloids	☐	☐
Diabetes	☐	☐
Immunosuppression	☐	☐
Chest pain	☐	☐
Fever or chills	☐	☐
Joint aches	☐	☐
Seizures	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

ALERTS

PLEASE CHECK ALL THAT APPLY

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Artificial joint replacement
- ☐ Allergy to topical antibiotics
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Are you pregnant or trying to get pregnant?
  Due Date ate (if pregnant) _____

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____ DATE: _____