## DERMATOLOGY & DERMATOLOGIC SURGERY CENTER, P.C.

SS#____/____/____ Patient Name _____ Nickname _____
First Middle Last

Home Phone: _____ Additional phone: _____

Home Address _____ Apt #_____
(Please use street address and P.O. Box if needed)

City _____ State _____ Zip Code _____

Sex: Male/Female Date of Birth____/____/_____ Marital Status: M S D W Race: _____

Ethnicity: Hispanic / Non-Hispanic Primary Language: English / Spanish _____

Patient Employer: _____ Work #:_____ Ext: _____

Family Doctor: _____
(Name, Address, and Phone Number)

Person financially responsible for this bill? _____ Relationship? _____

Their SS# _____ Their Address _____

Their Employer _____ Work Phone# _____

### Insurance Information

Primary Insurance Name _____ Policy Holder _____

Insurance Address _____ Employer _____

Policy/Group #'s _____ Policy Holder's Date of Birth _____

Secondary Insurance Name _____ Policy Holder _____

Insurance Address _____ Employer _____

Policy/Group #'s _____ Policy Holder's Date of Birth _____

### Authorization to Release and Assign Insurance Benefits and No Show Policy

I authorize release of my information to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to the above medical and or surgical benefits. I am entitled for the above listed services from my Insurance Company. This is to serve as a lifetime authorization. This authorization also applies to the treatment, payment and healthcare operations, as outlined in HIPAA regulations, and also for the RELEASE OF MEDICAL RECORDS to any physician whom I may be referred to by Dermatology and Dermatologic Surgery Center, P.C.

In signing this HIPAA form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

I understand and agree (regardless of my Insurance status) I am ultimately responsible for the balance of my account for any and all services rendered. I certify the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in my health status or above information.

**Appointments need to be cancelled at least 24 hours in advance.** I understand that there is a cancellation and/or no show fee charge of $35 incurred after the 2nd occurrence.

Signature: _____ Date: _____

Parent Signature (if minor): _____ Date: _____

☐ I would like a copy of a Notice of Privacy Practices

Patient Name: _____Date:_____

Do you wear sunscreen daily or whenever you are in the sun and what SPF do you use? _____SPF__

If you have had Atypical Mole, Actinic Keratosis (Pre-Cancerous Lesion), Basal Cell Skin Cancer, Squamous Cell Skin Cancer, or Melanoma treated in the past, please list where the lesion was located and year treated below:

_____

_____

_____

Have you ever had an excision for any lesion? _____
Have you ever had the MOHS surgery? _____

**Medication:**

**If you have a medication list, please let us know and we can make a copy.**

Please list any medications you currently take, **please include vitamins or supplements and creams**:

Medication:_____Dosage:_____How Often:_____How Taken:_____

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Are you taking any blood thinners? (Coumadin, Warfarin, Plavix, Aggrenox, Aspirin, Vitamin E, Lovenox, Pradaxa, Xalrato)

_____

Are you taking or using any contraception? _____

Have you had an Influenza (Flu) Vaccine? If yes, Month/Year_____ Refused _____ Allergy_____

Have you had a Pneumonia Vaccine? If yes, Month/Year_____ Refused _____ Allergy _____

Please list the pharmacy (Address/Location/City) you use and phone number if you know it:

_____

**Allergies:**

Please list any **medication allergies** including Latex and Lidocaine:

_____

_____

Patient Name: _____ Date: _____

PLEASE CHECK ANY CONDITIONS BELOW THAT **YOU** HAVE HAD OR CURRENTLY HAVE:

**Past Medical History:**

__Anxiety
__Arthritis
__Asthma
__Atrial Fibrillation (Irregular Heartbeat)
__Bone Marrow Transplantation
__Breast Cancer
__Colon Cancer
__COPD
__Coronary Artery Disease
__Depression
__Diabetes
__End Stage Renal Disease
__GERD
__Pacemaker
__Problems with bleeding
__Hearing Loss
__Hepatitis
__Hypertension
__HIV/AIDS
__Hypothyroidism
__Hyperthyroidism
__Leukemia
__Lung Cancer
__Lymphoma
__Prostate Cancer
__Organ Transplant
__Radiation Treatment
__Seizures
__Stroke
__History of Fainting

**Tobacco Use (Please check one):**

___Current Every Day Smoker ___Occasional Smoker ___Former Smoker ___Never Smoked

Are you currently pregnant, any chance that you are pregnant or planning a pregnancy? _____

**Please check and explain any surgeries that you have had below:**

__ Appendix (Appendectomy)
__ Gallbladder (Cholecystectomy
__ Breast Surgeries: _____
__Colon Surgeries: _____
__ Heart/Cardiac Surgeries: _____
__ Joint Replacements: _____
__ Kidney Surgeries: _____
__ Ovaries/Uterus: _____
__ Bladder (Cystecomy)
__ Spleen (Splenectomy)
Please list any not above: _____

**Skin Disease History:**

__Acne
__Actinic Keratosis (Pre-Cancer Lesions)
__Asthma
__Basal Cell Skin Cancer
__Squamous Cell Skin Cancer
__Precancerous/Atypical Moles
__Dry Skin
__Eczema
__Tanning Bed History
__Flaking or Itchy Scalp
__Hay Fever/Allergies
__Melanoma
Place of Birth: _____
__Poison Ivy
__Blistering Sunburns
__Psoriasis
__Family History of Melanoma
Family Member: _____