PATIENT INFORMATION

Name: ________________________________ Responsible Party (If minor):_____________________________

Address: ____ City: _______________ State: _____ Zip: ________

Home Phone: ___________________ Work Phone: ________________ Cell Phone: ________________________

E-Mail Address: ____ Sex: ________

DOB:___________ Marital Status: ___________________Name of Spouse: _____________________________

Primary Care Physician Name: _________________________ Allergic to any Medication: ___________________

In case of emergency, please contact: ___________________ Phone: _________________________________

Who referred you to our office? ____

OCCUPATION

Employer Name: ____

Address: ____

PLEASE PRESENT ALL INSURANCE CARDS TO FRONT DESK TO PHOTOCOPY

Primary Insurance Company Name: ____

Name of Insured (If different from Patient): _________________________ SS#: ________________________

Sex: ____ Marital Status: ____________________ DOB: ______________________

Relationship to Patient: _____________________________ Policy is through: Employer Individual

(If Applicable) Employer Name/Phone: ________________________ What is your copay? _________________

Secondary Insurance Company: ____

Name of Insured (If different from Patient): ____

Sex: __________ Marital Status: __________________ DOB: ______________________

Relationship to Patient: _____________________________ Policy is through: Employer Individual

(If Applicable)Employer Name/Phone: __________________ What is your copay? ______________________

I understand that regardless of insurance billing we provide you, unpaid balances are your responsibility. At the time of the visit, you must pay unmet deductible, co-payments, and non-covered medical services.

Patient Signature: ____ **Date:** ____________________________

Name: ____________________________ **Date:** ____________________

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Hepatitis
Arthritis	Hypertension
Artificial joints	HIV/AIDS
Asthma	Hypercholesterolemia
Atrial fibrillation	Hyperthyroidism
BPH (Benign prostatic hyperplasia)	Hypothyroidism
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD (Emphysema)	Pacemaker
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD (Acid Reflux)	Valve Replacement
Hearing Loss	None

Other ____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP (Transurethral Resection of the Prostate)
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA (Angioplasty)	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None

Other ____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Other ____

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

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ____
Any other family history: ____

Medications: (Please enter all current medications)

____
____
____

Allergies: (Please enter all allergies)

____
____
____

Pharmacy Name: ____
Address: ____
Phone #: ____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Illicit Drug Use:
- Drug Use
- IV Drug Use

Safety:
- I feel safe at home.
- I do not feel safe at home

Other______________________________________ None

Review of Systems:Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
Changing mole		
Rash		
Abdominal pain		
Anxiety		
Bloody stool		
Bloody urine		
Blurry vision		
Chest pain		
Cough		
Depression		
Fever or chills		
Headaches		
Hay fever		
Joint aches		
Muscle weakness		
Neck stiffness		
Night sweats		
Seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional weight loss		
Wheezing		

Other Symptoms: ____

Alerts: Do you have any of the following? (please check yes or no for the following)

Alert	Yes	No
Pacemaker		
Artificial joints within past two years		
Artificial heart valve		
Premedication prior to procedures		
Defibrillator		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Allergy to lidocaine		
Rapid heart beat with epinephrine		
Yeast infections with antibiotics		
GI upset with antibiotics		

Other Symptoms: ____