COMPLETE DERMATOLOGY

NEW/UPDATED PATIENT INFORMATION

Today's Date | First Name | MI | Last Name

Address | City | State | Zip

Home Phone | Work Phone | Cell

Email Address | Date of Birth

Age | Male/Female Sex | Marital Status

Referring Physician's Name | Referring Physician's Phone #

Other Family Members Who Visit Our Practice

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Primary Insurance Name	Secondary Insurance Name
Insured's Name	Insured's Name
Insured's Social Security	Insured's Social Security
Policy # Group #	Policy # Group #
Self ☐ Spouse ☐ Child ☐ Other ☐	Self ☐ Spouse ☐ Child ☐ Other ☐
Insured's Employer Insured's DOB	Insured's Employer Insured's DOB

OTHER INFORMATION

Current Employer | Occupation | Yes/No Full-time Student

Emergency Contact Name | Emergency Contact Phone # | Relationship

Parent or Guardian Name (If patient is minor) | Physician/Friend/Family/Google/Other How did you hear about us?

COMPLETE DERMATOLOGY

HIPAA and Privacy Disclosures

- Please note that we communicate results through the patient portal of our EMR. Your portal will be set up on your first visit at Complete Dermatology. The website for the portal is completederm.ema.md. Your login for the portal is your email address. If you do not have access to an email address, please notify the staff.
- The Complete Dermatology privacy notices are posted and available every time you come in to our office. By signing below, you acknowledge that you have read and understand this information.
- You can give permission for Complete Dermatology to release information to others whom may assist in your care. Please list all names below who you give permission to release information to:

Name	Relationship	Phone Number

Options for Payments

Please see the options below on how to pay your portion of services rendered: ***(Check one option below)***

- o I DO prefer to participate in the credit card on file program. My credit card will remain on file until I cancel this agreement. I will notify Complete Dermatology with any changes in the credit card information. I understand that I will be notified via email at least two days prior to the card being charged any amount due after my insurance has processed my claim.
- o I DO NOT want to participate in the credit card on file program. I will be responsible to pay my estimated portion by cash, check or credit card each visit. Any amount owed after my insurance processes will be due 30 days from the statement date. If my account becomes delinquent, I may be charged a 25.00 service charge and my account could be sent over to a collection agency.

Medical Records

Have you seen either Dr. Payne or Dr. Bumgardner within the past 3 years? **YES** **NO**

If yes, please fill out the Medical Records release form from Woodlands Dermatology. Woodlands Dermatology may charge the patient a reasonable and customary fee for these records..

By signing below, you acknowledge you have read and understand these disclosures. This consent will remain in effect unless otherwise revoked in writing.

Signature of Patient	Date

Printed Print Name of Patient	Signature of Legal Guardian	Date

COMPLETE DERMATOLOGY

Medical Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

How did you find us? **Internet/ Family or Friend**(Name: _____)/ **Physician** (Name: _____)

The reason for today's visit: _____

How long has this issue or illness been present?_____

What have you tried to treat it? _____Pharmacy Name &Number_____

Select any of the following medical conditions that you currently have:

_____None _____Anxiety _____Arthritis _____Asthma

_____Atrial Fibrillation _____ Bone Marrow Transplant _____BPH _____Breast Cancer

_____Colon Cancer _____COPD _____Coronary Artery Disease _____Depression

_____Diabetes _____End Stage Renal Failure _____GERD _____Hearing Loss

_____Hepatitis _____Hypertension _____HIV/AIDS ____High Cholesterol

_____Hyperthyroidism _____Hypothyroidism _____Leukemia _____Lung Cancer

_____Lymphoma _____Prostate Cancer _____Radiation Treatment _____Seizures

_____Stroke _____Other:_____

Please List All Past Surgeries:

Year_____Surgery Performed_____ Year_____Surgery Performed_____

For FEMALES only: Are you breastfeeding or trying to get pregnant? Yes/No

Have you had any of the following skin conditions?

_____None _____Acne _____Actinic Keratoses _____Asthma

_____Basal Cell Carcinoma _____Blistering Sunburns _____Dry Skin _____Eczema

_____Flaking or Itchy Scalp _____Hay Fever/Allergies _____Melanoma _____Poison Ivy

_____Precancerous Moles _____Psoriasis _____Squamous Cell Carcinoma _____Other

Name: _____ Today's Date: _____

If you have had Basal Cell, Squamous Cell or Melanoma, please indicate location of the body below.

_____

Do you wear Sunscreen? Yes/No If so, what SPF? _____ Do you use a tanning salon? Yes/No

Family History
Do you have a family member with Melanoma? Yes/No If yes, which relative? _____

Current Medications: Please list the medication and the dosage and how many times per day you take it.

Medication Name	Strength	How many times per day
Medication Name	Strength	How many times per day
Medication Name	Strength	How many times per day
Medication Name	Strength	How many times per day

Do you have any allergies: Please list below

_____ Allergy and type of reaction

_____ Allergy and type of reaction

_____ Allergy and type of reaction

_____ Allergy and type of reaction

Other Information:

Do you smoke? Yes/No If yes, how many packs per day?_____ Total years smoking? _____

Do you use drugs? Yes/No If yes, have you used IV drugs? How long?_____

Do you drink Alcohol? Yes/No If yes, how many per day? _____

Please use this space to add additional information, surgeries, or medications:

_____

_____

Name:_____ **Today's Date:**_____

Do you have a history of the following? Please indicate YES OR NO.

RASH	YES/NO
PROBLEMS WITH SCARRING	YES/NO
PROBLEMS WITH HEALING	YES/NO
HISTORY OF MELANOMA	YES/NO
ARE YOU TAKING BLOOD THINNERS	YES/NO
PROBLEMS WITH BLEEDING	YES/NO
PACEMAKER OR DEFIBRILLATOR	YES/NO
ALLERGY TO LATEX OR ADHESIVES	YES/NO
ALLERGY TO LIDOCAINE	YES/NO
ACHY JOINTS	YES/NO
ALLERGY TO TOPICAL ANTIBIOTIC OINTMENTS	YES/NO
ARTIFICIAL HEART VALVE	YES/NO
ARTIFICIAL JOINTS WITHIN LAST 2 YEARS	YES/NO
SHORTNESS OF BREATH	YES/NO
PREMEDICATE PRIOR TO PROCEDURES	YES/NO
IMMUNOSUPPRESSION	YES/NO
HAY FEVER	YES/NO
CHEST PAIN	YES/NO
FEVER OR CHILLS	YES/NO
NIGHT SWEATS	YES/NO
UNINTENTIONAL WEIGHT LOSS	YES/NO
THYROID PROBLEMS	YES/NO
SORE THROAT	YES/NO
BLURRY VISION	YES/NO
ABDOMINAL PAIN	YES/NO
MUSCLE WEAKNESS	YES/NO
NECK STIFFNESS	YES/NO
HEADACHES	YES/NO
SEIZURES	YES/NO
COUGH	YES/NO
DEPRESSION	YES/NO