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

NOTICE OF POLICY

PATHOLOGY: When biopsies or excisions are performed in the office, it takes up to 2 weeks to receive the results from the pathology lab. **WE WILL ALWAYS EMAIL YOU THE RESULTS THAT ARE NORMAL OR BENIGN. If your path or lab results are abnormal, we will call you.** As notified in our Financial Policy, charges may be incurred when biopsies or other excisions are performed. By signing this form you understand the policy and give us permission to call and/or email you with results for laboratory and pathology. ***IF YOU DO NOT ACCEPT EMAILS CHECK HERE.*** ☐

REMINDER CALLS/RECALLS: Our system is set up to text and email you reminders of your upcoming appointments or when it is time to schedule an appointment. IF you do not have a cell phone or email, then you will receive a phone call. It is your responsibility to notify the office at least 24 hours if you need to cancel an appointment. See the Financial Policy for more information on this.

RELEASE OF INFORMATION: I give permission to discuss all of my medical information with the following person(s): _____

Name DOB Relationship

_____

Name DOB Relationship

OPTIONS FOR PAYMENT: We accept cash, check, and most credit cards. Please read below:

☐ I DO prefer to participate in the credit card on file program. My credit card will remain on file until I cancel the agreement. This option allows the patient to get notifications via email with all amounts due after insurance has processed rather than getting regular paper statements.

☐ I DO NOT want to participate in the credit card on file program. I will be responsible to pay my bill by cash, check or credit card at each visit. Any amount owed after my insurance has processed will be due within 30 days from the day the statement is received. At any time that the account becomes delinquent, a 25.00 service charge will be placed on the account and the account will be sent to a collection agency.

By signing below, you acknowledge you have read and understand these disclosures as well as the Financial Policy that was provided to you on your first visit. If you need to review the Financial Policy, or if for any reason you need further explanation, please see the receptionist. This consent will remain in effect unless otherwise revoked in writing.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

PRINT PATIENT NAME HERE PATIENT'S DATE OF BIRTH

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