

**Patient Information for
The Center for Dermatology, P.C.**

ADULT FORM

PLEASE PRINT

A. Patient's Name _____
(Last) (First) (Middle) (Preferred)

Address _____ Date of Birth _____

_____ Home Phone _____

e-mail _____ Cell Phone _____

Employed By _____ Business Phone _____

Occupation _____ Social Security # _____

Marital Status _____ Gender _____ M _____ F

B. Spouse's Name _____ Spouse's DOB _____

Employed By _____ Social Security # _____

Occupation _____ Business Phone _____

e-mail _____ Cell Phone _____

C. Patient's Primary Insurance _____ Contract Number _____

Secondary Insurance _____ Contract Number _____

D. Name of friend or relative not living at patient's same address _____

Address _____ Phone _____

Who may we thank for the referral? _____

Name of Primary Care Physician _____

ALLERGIES: Are you allergic to any medications? Yes No If yes, please list the medications and type of reactions you experienced. _____

MEDICATIONS: Please list all prescription and over the counter medications you take on a regular schedule (include aspirin, birth control pills, thyroid supplement, laxatives). _____

PAST MEDICAL HISTORY:

Do you currently have, or have had in the past, any form of cancer (including skin cancer)? _____

If skin cancer, what type? _____

If female, are you pregnant or lactating? _____

Have you been told you have the following? (Please check all items either "yes" or "no")

ALLERGY	Yes	No	AUTOIMMUNE DISEASE	Yes	No
Food	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Ointments, Creams Lotions	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Make-Up	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>
Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever, Sinus, Eyes	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS SYSTEM	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR	Yes	No	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY	Yes	No
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	COPD, Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD	Yes	No	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Any additional medical conditions _____

Has anyone in your family had a history of any of the following? (Please check all that apply)

- | | | | |
|-------------------------------------------|------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Other Skin Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding Disorder |

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

“I give permission to The Center for Dermatology, P.C. to submit full medical records, within discretion, to my insurance companies if they so request and to other physicians that I am consulting if they so request.”

Legal Signature

Date

AUTHORIZATION OF BENEFITS

“I hereby authorize any payment due on my claim to be paid directly to The Center for Dermatology, P.C.” In addition, I agree to pay for the services I received which are not covered by my medical insurance. (These services may include elective cosmetic procedures such as Botox, Collagen, sclerotherapy and laser.)”

Legal Signature

Date

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Center for Dermatology, P.C., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Center for Dermatology, P.C.’s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received the practice’s Notice of Privacy Practices prior to signing this consent. The Center for Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Center for Dermatology, P.C. Privacy Officer at 4310 Old Shell Road, Mobile, Alabama 36608.

With my consent, The Center for Dermatology, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, The Center for Dermatology, P.C. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to The Center for Dermatology, P.C.’s use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, The Center for Dermatology, P.C. may decline to provide treatment to me.

Legal Signature

Date

Periodically, The Center for Dermatology, P.C. studies new, state of the art treatment for various skin diseases. Would you like to be notified of these research protocols? Yes No