Patient Information (Please Print)

Name: _____ Sex: M F Age: _____ Date of Birth: _____

Address: _____ Marital Status: Single Married Partnered Widowed Divorced

City: _____ State: _____ Zip: _____ SSN **OR** Drivers License #: _____

Email: _____ Preferred Language: English Other: _____

Primary Phone: ( ) _____ Ok to leave message? YES NO

Alternate Phone: ( ) _____ Ok to leave message? YES NO

Work Phone: ( ) _____ Employer: _____

Do we have permission to discuss your medical condition with a member of your household? ____ Yes ____ No

If yes, with whom? _____ Relationship? _____

Name of your Primary Care Physician: _____ Phone Number: _____

Did a physician or friend/ family refer you? ____ Yes ____ No If Yes, Who? _____

Ethnicity (cultural): (European/White) (Asian) (Black/African Amer) (Hispanic/Latino) (American Indian/Alaska Native)

Race (physical): (White) (Black/African American) (Asian) (Hispanic) (Indian) (Hawaiian/Pacific Islands) (Unknown)

All prescriptions are now sent electronically. In order to receive a prescription, we MUST have the following :

Pharmacy Name: _____ Address: _____ Phone: _____
(not mail order)

Responsible Party/ Primary Insurance Holder: ☐ **Same as above**

Name: _____ Sex: M F Date of Birth: _____

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip: _____ Employer: _____ Phone: _____

Home Phone: ( ) _____ Relationship to patient: _____

Insurance Information

Primary Insurance: _____ ID # and Group #: _____/_____

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

Insured's Relationship to Patient: (Please Circle) Spouse Parent Step-Parent Child Other

Secondary Insurance: _____ ID # and Group #: _____/_____

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

Insured's Relationship to Patient: (Please Circle) Spouse Parent Step-Parent Child Other

Authorization to Release Medical Information

Permission is granted to Clayton Dermatology LLC (CDLLC) for treatment of the patient identified above. I hereby direct my insurance benefits be paid directly to CDLLC. I authorize claims to be filed electronically. Furthermore, I authorize my insurance company, employer and/or any other party responsible to exchange information with the doctor as needed to secure guarantee of payment for services from this office. I accept full responsibility for obtaining a referral from my primary care physician when necessary. I understand I am financially responsible for deductibles, co-payments and any charges either not covered or denied by my insurance plan or responsible party. I have received a copy of CDLLC'S Notice of Privacy Practices.

Signed: Patient or Guardian: _____ Date: _____

PLEASE COMPLETE ALL AREAS BELOW

Reason for today's visit:_____

Do you have any allergies to medications or have you had any adverse reactions to any medications (ie, rash, shortness of breath, dizziness) □ YES □ NO **If yes, please list name of medication and symptom**: _____

Do you take any medications (including prescriptions, over-the-counter, vitamins & herbs): YES NO
Do you take blood thinners YES NO (Coumadin, Plavix, Aspirin, Vitamin E Ibuprofen Aleve)
List all medications you are currently taking (Include all oral contraceptives, prescriptions, over-the-counter, vitamins & herbs):

Medication Name	Strength (60 mg, etc)	Dosage (1 tablet daily, etc)

Do you have now, or have you ever had any of the diseases or conditions listed below? (Please check YES or NO)

Condition:	YES	NO		Condition:	YES	NO		Condition:	YES	NO
Seasonal Allergies	□	□		Heart Attack/Stroke	□	□		Diabetes		
Asthma	□	□		Heart Murmur	□	□		Thyroid		
Chest pain	□	□		Irregular Heartbeat	□	□		Hepatitis		
Cancer	□	□		Blood Clots	□	□		Tuberculosis		
High blood pressure	□	□		Pacemaker	□	□		Arthritis		
High Cholesterol	□	□		Liver Disease	□	□		Anxiety/depression		
Please comment on any condition that you indicated YES on:										
Have you **EVER** experienced any itching or rash from any medications? If so, name of the medication:										
While on antibiotics, have you experienced: Nausea, vomiting, diarrhea, or yeast infections (please circle which applies)										

Please list any other medical conditions or diseases: (examples: **Cancer, Kidney Disease, Radiation or Other known laboratory abnormalities)**_____
Please list any surgical procedures you have had: _____
Do you have any artificial joints/heart valves or other implants? Yes□ No □ If **yes**, Please list: _____

Skin:	YES	NO	
Have you ever had skin cancer?	□	□	If yes, which type? _____
Has anyone in your family had skin cancer?	□	□	If yes, which type? _____
Do you have a history of any skin diseases?	□	□	If yes, which type? _____
Do you have any problem with healing?	□	□	
Do you develop keloids (scars) after surgery	□	□	
Have you ever had a sunburn?	□	□	
Have you ever used a tanning bed?	□	□	**Currently**? How long/often?
Do you bleed easily?	□	□	
Do you develop skin rashes in reaction to □ Medications □ Bandages □ Other: _____			
Social History:	**YES**	**NO**	
Do you drink alcohol?	□	□	If yes, how many drinks per day?
Do you smoke now or have you in past?	□	□	Everyday? Y N How many per day?
Have you ever been exposed to HIV/AIDS?	□	□	

Because environmental factors influence certain skin conditions, please answer the following questions:
What is your occupation? _____ Where did you grow up?_____
(Women) Are you pregnant **or are you trying** to get pregnant? □ Yes □ No Are you nursing? □ Yes □ No
Name of person completing form: _____ Relationship to Patient: _____

Patient/Guardian Signature: _____ Date: _____ Updated: _____

Reviewed by: _____ Date: _____ Updated: _____