DERMATOLOGY, P.L.C.

PATIENT'S ***FULL*** * NAME_____
*** no initials please (FIRST) (MIDDLE or MAIDEN) (LAST)**
IF PATIENT IS A MINOR: Parent/guardian name:_____

BILLING ADDRESS:_____CITY:_____ ZIP: _____

PATIENT SS#_____ PATIENT BIRTH DATE: _____
CELL PHONE : _____
HOME PHONE: _____EMPLOYER:_____WORK PHONE:_____

REFERRED BY:_____ SEX: M F EMERGENCY CONTACT: _____phone#_____

INSURANCE CO.:_____**Subscriber's name:**_____**Subscriber's birthdate:**_____

RESPONSIBLE PARTY SS#_____
Females: **pregnant? Y N nursing? Y N trying to conceive? Y N**
Everyone: Do you or did you ever smoke: Y N # of packs/day _____ # of years _____
Drink alcohol? Y N amount _____
Have you had hepatitis? Y N Have you been tested for HIV? Y N Results:_____

DRUG ALLERGIES:	**CURRENT MEDS:**	**CURRENT HEALTH PROBLEMS:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYMPTOMS: Please circle ALL symptoms that you are now having:
General Health – fever, nausea, weight loss, loss of appetite, cancer, diabetes
Skin-itching, rash, hair loss, nail problems, growths, skin cancer, psoriasis, eczema
Endo-thyroid disease, excess hair growth, change in sex drive, breast discharge
Psychiatric-depression, mania, obsession, anxiety, neurosis, stress
Blood Disorders-anemia, leukemia, bleeding disorders, blood thinners
Allergic/Immunologic- lupus,scleroderma,vitiligo, polymyositis
Other (please explain) –

*** I authorize the release of any medical information necessary to process this claim and any future claims. I also authorize payment of medical benefits to this provider should he accept assignment on this claim. I've Been made aware that this office's HIPAA notice is posted in the waiting room and I may request a copy.**

SIGNATURE: _____ **DATE:** _____

PARENTAL CONSENT FOR CHILD UNDER 18 YEARS OF AGE

I am present with my child _____today and I give my consent to Dermatology, P.L.C. to see and treat my child as indicated. If his/her condition requires follow-up, I give permission for continued office care in my absence (No invasive procedures will be performed without direct notification to the parent.)

SIGNATURE OF PARENT OR GUARDIAN: _____