



Precision Dermatology and Skin Surgery, PA

Board Certified in Dermatology
Fellowship trained in Dermatologic Surgery

PATIENT INFORMATION			
NAME (LAST, FIRST, MIDDLE INITIAL)		NICKNAME	DATE OF BIRTH
SOCIAL SECURITY #	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
PRIMARY ADDRESS			APARTMENT/UNIT
CITY		STATE	ZIP
CELL PHONE	HOME PHONE	EMAIL ADDRESS	
RACE <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Multi-racial		<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Declined to Specify	ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Declined to Specify
RESPONSIBLE PARTY INFORMATION (FOR MINOR OR LEGAL GUARDIANS ONLY)			
RESPONSIBLE PARTY NAME		RELATIONSHIP TO PATIENT	
CELL PHONE		HOME PHONE	
POWER OF ATTORNEY (IF YES, PLEASE PROVIDE PAPERWORK) <input type="checkbox"/> Yes <input type="checkbox"/> No			
ADDITIONAL HEALTHCARE INFORMATION			
PRIMARY CARE PHYSICIAN		PRIMARY CARE PHONE NUMBER	
PHARMACY NAME		PHARMCY PHONE NUMBER	
<input type="checkbox"/> I AUTHORIZE PRECISION DERMATOLOGY AND SKIN SURGERY TO IMPORT A LIST OF MY CURRENT MEDICATIONS FROM MY PHARMACY TO USE AS PART OF MY MEDICAL RECORDS			
ADVANCED CARE PLAN			
DO YOU HAVE A HEALTH CARE PROXY IN THE EVENT YOU ARE UNABLE TO MAKE YOUR OWN MEDICAL DECISIONS? <input type="checkbox"/> Yes <input type="checkbox"/> NO			
DESIGNEE'S NAME		PHONE NUMBER	
EMERGENCY INFORMATION			
EMERGENCY CONTACT NAME		RELATION	PHONE NUMBER

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____ DATE: _____



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AUTHORIZATIONS

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I authorize payment to my doctor and/or Precision Dermatology and Skin Surgery, P.A. of any health insurance benefits that are payable to me, including but not limited to Medicare payments, "Medigap" payments, and/or payments from private insurance companies. I certify that the information that I gave to my doctors and/or Precision Dermatology and Skin Surgery, P.A. to bill for payment is correct. I assign and transfer to Precision Dermatology and Skin Surgery, P.A., my doctors and/or hospital or their hospital or their agents to the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due. I understand that I must pay my doctors and/or Precision Dermatology and Skin Surgery, P.A. for all charges not paid by my health insurance. This payment authorization, assignment of benefits, and agreement for financial responsibility is also binding to my administrators, executors, heirs, and successors. Although Precision Dermatology and Skin Surgery, P.A. collects an estimate of patient responsibility at the time of service, I understand Precision Dermatology and Skin Surgery, P.A. will bill me for any additional cost associated with the care given by Precision Dermatology and Skin Surgery, P.A. I have read this assignment of benefits, I understand this assignment of benefits, and my questions have been answered.

Patient / Authorized Party Signature: _____

Name: _____ Witness Initial: _____

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I understand Precision Dermatology and Skin Surgery, P.A. and/or my doctor is allowed to use and disclose my health information for treatment, payment, or operations and I understand Precision Dermatology and Skin Surgery, P.A. and/or my doctors to release this information as allowed by law. I understand that when Precision Dermatology and Skin Surgery, P.A. uses and discloses my health information as described in this authorization, the doctor and/or Precision Dermatology and Skin Surgery, P.A. may disclose general information contained within my medical record. I understand that full disclosure of my HIV, drug and alcohol abuse or mental health treatment record will not occur without my specific written consent relating to these conditions. My signature below means I have read this authorization and I understand this authorization to release my health information.

Patient / Authorized Party Signature: _____

Name: _____ Witness Initial: _____

CANCELLATION POLICY

There will be a \$35 cancellation fee for all appointments re-scheduled less than 24 hours from appointment time

I am aware of the \$35 cancellation / re-schedule fee

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____ DATE: _____



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PATIENT NAME: _____

PATIENT MEDICAL HISTORY		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cancer: Prostate	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Arthritis	<input type="checkbox"/> COPD	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Depression	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer: Breast	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer: Colon	<input type="checkbox"/> Hearing Loss	
<input type="checkbox"/> Cancer: Leukemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> NONE
<input type="checkbox"/> Cancer: Lung	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Cancer: Lymphoma	<input type="checkbox"/> HIV	
Other: _____		

PAST SURGICAL HISTORY		
<input type="checkbox"/> Appendix Removed	<input type="checkbox"/> Mechanical Valve Replacement	
<input type="checkbox"/> Biological Valve Replacement	<input type="checkbox"/> Transplant: Heart	
<input type="checkbox"/> Biopsy: Breast	<input type="checkbox"/> Transplant: Kidney	
Circle: Right, Left Bilateral	<input type="checkbox"/> Transplant: Liver	
<input type="checkbox"/> Biopsy: Prostate	<input type="checkbox"/> Removal: Kidney	
<input type="checkbox"/> Colectomy	Circle: Right, Left	
<input type="checkbox"/> Gallbladder Removed	<input type="checkbox"/> Removal: Ovaries	
<input type="checkbox"/> Coronary Artery Bypass	Circle: Right, Left	
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Removal: Prostate	
<input type="checkbox"/> Joint Replacement: Knee	<input type="checkbox"/> Removal: Spleen	
Circle: Right, Left, Bilateral	<input type="checkbox"/> Removal: Testicles	
<input type="checkbox"/> Joint Replacement: Hip	Circle: Right, Left	
Circle: Right, Left, Bilateral		
<input type="checkbox"/> Lumpectomy: Breast	<input type="checkbox"/> NONE	
Circle: Right, Left, Bilateral		
<input type="checkbox"/> Mastectomy		
Circle: Right, Left		
Other: _____		

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SKIN DISEASE HISTORY		
<input type="checkbox"/> Acne	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Poison Ivy
<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Precancerous Moles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Flaking or Itchy Scalp	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Basal Cell Carcinoma	<input type="checkbox"/> Hay Fever / Allergies	<input type="checkbox"/> Squamous Cell Carcinoma
<input type="checkbox"/> Blistering Sunburns	<input type="checkbox"/> Melanoma	
<p>If you have a history of melanoma, please include any pertinent treatment information on the lines below.</p> <p>Other: _____</p> <p>_____</p> <p>_____</p>		
<p>Do you wear Sunscreen? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what SPF? _____</p> <p>Do you tan in a tanning salon? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
SKIN CANCER FAMILY HISTORY		
<p>Do you have a FAMILY history of melanoma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, which relative(s)? _____</p> <p>Family history of Other Skin Cancer (Only first-degree relatives. This includes parents, children, brothers, and sisters)</p> <p>_____</p> <p>_____</p>		
MEDICATIONS		
<p>PLEASE INCLUDE STRENGTH AND FREQUENCY USED. IF YOU ARE NOT TAKING ANY MEDICATIONS, PLEASE WRITE NONE</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		
ALLERGIES		
<p>PLEASE LIST ALL MEDICAL ALLERGIES. IF YOU ARE NOT ALLERGIC TO ANY MEDICATIONS, PLEASE WRITE NONE</p> <p>_____</p> <p>_____</p> <p>_____</p>		

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SOCIAL HISTORY		
CHECK ALL THAT APPLY		
Cigarette Smoking: <input type="checkbox"/> Current Smoker Packs per day _____ <input type="checkbox"/> Never smoked <input type="checkbox"/> Former smoker	Alcohol Use: <input type="checkbox"/> None <input type="checkbox"/> Less than 1 drink per day <input type="checkbox"/> 1-2 drinks per day <input type="checkbox"/> 3 or more drinks per day	
PNEUMONIA VACCINATION		
HAVE YOU RECEIVED A PNEUMONIA VACCINATION? <input type="checkbox"/> Yes <input type="checkbox"/> No		
REVIEW OF SYSTEMS		
ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?		
SYMPTOM	YES	NO
Problems with bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>
Form keloids	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
Joint aches	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
ALERTS		
PLEASE CHECK ALL THAT APPLY		
<input type="checkbox"/> Allergy to adhesive <input type="checkbox"/> Allergy to lidocaine <input type="checkbox"/> Artificial joint replacement <input type="checkbox"/> Allergy to topical antibiotics <input type="checkbox"/> Blood thinners <input type="checkbox"/> Defibrillator	<input type="checkbox"/> MRSA <input type="checkbox"/> Pacemaker <input type="checkbox"/> Require antibiotics prior to procedure <input type="checkbox"/> Rapid heartbeat with epinephrine <input type="checkbox"/> Are you pregnant or trying to get pregnant?	

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

PRINT NAME: _____

DATE: _____