Personal Information (of Patient):

Last Name: _____ First Name: _____ Middle Initial: _____

Address _____ Date of Birth _____/____/_____ SSN _____ - _____ - _____

City, State, ZIP:_____ Sex: Male Female

Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____ Referred By_____

Employer _____ Work Phone _____ - _____ -_____ext:_____ Email: _____

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ 18 years old or younger

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Do not wish to provide

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Do not wish to provide Preferred Language: ☐ English ☐ Other: _____

Emergency Contact: _____ _____
Last Name First Name

_____ - _____ - _____ _____ - _____ - _____ Ext _____ _____
Home Phone Work/Cell Phone Relationship to patient

Insurances: ***(Please fill this out even if cards have already been provided)***

Primary Insurance: _____		Secondary Insurance _____	
Ins. ID # _____	Group # _____	Ins. ID # _____	Group # _____
_____ _____	_____	_____ _____	_____
Subscriber Name	D.O.B Rel. to patient	Subscriber Name	D.O.B Rel. to patient

~~Subscriber Information~~

HIPAA Acknowledgement:

I, _____, have been presented with and read a Privacy Notice explaining my rights regarding my Individually Identifiable Health Information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other healthcare operations. Other uses of my IIHI will require an authorization from me for the specific intention of disclosure. If there are any parties that I wish to be privy of any or all of my IIHI including family members (eg. spouse, significant other, children, parents etc), I will indicate below.

_____ _____ _____
Signature of Patient/Parent/Guardian Printed Name Date

You may discuss biopsy results with the following individual, _____, ☐ at all times, ☐ when I am unavailable or ☐ when there is an emergent/life-threatening circumstance.

Billing Authorization:

I, _____, hereby authorize AllPhases Dermatology, LLC, to apply for benefits on my behalf for covered services rendered by AllPhases Dermatology and request that the payments from Medicare and/or _____ be made directly to AllPhases Dermatology, LLC (or, in the case of Medicare Part B, to myself or to the party who accepts assignment).

I certify to the information I have reported with regard to my insurance coverage and further authorize the release if any necessary information, including medical information for this or any related claim, to the billing agent, (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration)/Medicare and/or _____. I also agree to pay any and all collection and attorney fees in the event of non-payment. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me, or the above named carrier, in writing at any time.

_____ _____ _____
Signature (Patient/Parent/Guardian) Printed Name Date

AllPhases Dermatology Policies Acknowledgement

I acknowledge that I have been presented with and read the policies governing the practice of AllPhases Dermatology, LLC and will adhere to them. If there are any circumstances that will prevent me from abiding by these rules, I will discuss and receive a waiver at the sole discretion of the Office Administrator of AllPhases Dermatology, LLC. I hereby agree to be responsible for any violation of any of these policies monetarily or otherwise.

_____ _____
Signature (Patient/Parent/Guardian) Printed Name

MEDICAL INFORMATION

PATIENT NAME: _____

Reason for today's visit – *Please limit complaints to no more than two (2) per visit*

Complaint #1	When did it start?	Where on your body?	Symptoms: (itch, bleed, pain, flaking, etc.)	Getting better or worse?

Any treatments in past or present?	Has this happened before?	What makes it better?	What makes it worse?

Complaint #2	When did it start?	Where on your body?	Symptoms: (itch, bleed, pain, flaking, etc.)	Getting better or worse?

Any treatments in past or present?	Has this happened before?	What makes it better?	What makes it worse?

Medical History *(Circle any that apply to your past or current history. Indicate N/A when nothing applies within any box)*

Anemia	Impaired hearing
Arsenic exposure	Heart disease
Arthritis	Heart murmur
Blood disease (e.g. sickle cell)	High blood pressure
Boils	High cholesterol
Cancer	Irregular menstrual periods
Colitis	Kidney disease
Colonic polyps	Liver disease/Hepatitis
Diabetes	Lung problems (e.g. Asthma)
Ear, Nose and Throat problems	Radiation exposure
Exposure to chemical toxins	Rheumatoid Arthritis
Eye disease	Seizure disorder
Fevers	Stroke
Gallbladder disease	Swollen glands
Glaucoma	Thyroid disease
Gout	Tuberculosis
Hay fever	Ulcers/Stomach problems
Headaches	Weight gain or loss

Dermatology History *(Circle any that apply to you in the past or currently)*

Acne	Nail problems
Dry skin	Other
Eczema	Psoriasis
Fungus (Ringworm)	Shingles/Zoster
Hair loss	Skin infection
Hives	Skin cancer (type and when treated)
Keloids	Warts

I am attempting to get pregnant (females only)
I am currently pregnant (females only)
I am a nursing mother (females only)
I need antibiotics prior to dental/surgical procedures
I have a history of mouth or gum disease
I have a history of Lupus or Scleroderma
I have a history of Sarcoidosis
I have a history of HIV or AIDS
I have a history of Depression or other mood disorders

Allergies to:

Medications:

Foods:

Other:

Surgical History *(List all past surgeries you have had)*

Personal Profile: Occupation:

Do you smoke? (amt?) Do you drink? (amt?)

Family history of skin disorders such as Cancer, Psoriasis, etc.:

Family Health History: Has any family member had any of the following? *Indicate F = Father, M = Mother, S = Sibling, C = Child*

Diabetes: _____	Hypertension: _____	Heart Disease: _____	Stroke: _____
Mental Illness: _____	Cancer: _____	Unknown: _____	

Current Medications: *(including over-the-counter meds, herbal supplements, vitamins)*

Please attach copy of Medical Insurance (back side) here