AUBURN DERMATOLOGY

PATIENT DEMOGRAPHIC

(Please print legibly)

Patient Legal Name: ____DOB: ______ M/F______

Home Phone: _________________Work Phone: __________________Cell Phone: __________________

Mailing Address: _______________________________City: _________________State: _____Zip: _____

Preferred Email: ____

Married: _____ Single: _____ Widowed: _____ Divorced: ______ Legally Separated: _____

Emergency Contact Name and Relationship: ____

Emergency Contact Phone Number: ____

Do you live alone? _______ Do you drink alcohol? _________ Frequency: __________________________

Primary Care Physician Name: ____

Insurance Company: _________________________ Ins. ID #: ___________________________________

Have you satisfied your deductible? Yes/No

Subscriber Name: ____

Subscriber Address: _____________________________________City: __________ State: _____ Zip:____

Subscriber DOB: ___________________________Relationship to Subscriber: ________________________

Name of Prescription Plan: ________________ Prescription Plan ID #_______________________________

Name and Address of Pharmacy: ____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I understand that I am responsible for any and all moneys not paid by my insurance. I will notify you of any changes in the above information. I also understand that it is my responsibility to get a referral from my primary care, if my insurance requires this. I understand that I will be held responsible if my insurance does not pay Auburn Dermatology because of an missing referral. I, the undersigned/guardian, have read the new patient brochure and understand the training, credentialing, and experience of all practitioners in the clinic.

____

PATIENT RESPONSIBLE PARTY RELATIONSHIP DATE SIGNED

AUBURN DERMATOLOGY

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner (check all that apply):

___Home Telephone # __________________

___ OK to leave a message with call-back number only

___ OK to leave a message with detailed health information

___Work/Cell Telephone # ________________

___ OK to leave a message with call-back number only

___ OK to leave a message with detailed health information

VERBAL RELEASE OF INFORMATION

Auburn Dermatology is allowed to give verbal medical information or updates about your condition to your Power of Attorney or Healthcare/Legal Representative as listed in your medical record. If you wish others, such as relatives or friends, who ask about your condition, the right to be verbally informed about your condition when they ask, please list the names of those people on the lines below.

I am authorizing the release of verbal medical information regarding my treatment, care and updates on my condition to the following individuals:

Name: ____ Relationship: _________________________

Name: ____ Relationship: _________________________

Name: ____ Relationship: _________________________

- I understand that Auburn Dermatology will continue to rely on the information on this form when communicating with others involved in my care unless I request changes.
- I understand that I may revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing and the revocation will not apply to information that has already been disclosed prior to receipt of written revocation.

____ __________________

Patient/Guardian Signature Date

____

Patient's Printed Name

Patient Name: ____

<u>History and Intake Form</u>

Past Medical History (please circle all that apply)

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Artificial Joints	End Stage Renal Disease	Lung Cancer
Asthma	GERD	Lymphoma
Atrial Fibrillation	Hearing Loss	Pacemaker
BPH	Hepatitis	Prostate Cancer
Bone Marrow Transplantation		Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	Hypercholesterolemia	Valve Replacement
Coronary Artery Disease	Hyperthyroidism	None

Other: ____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removed
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement –Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement – Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None

Other: ____

Name and Location of Pharmacy : ____

Patient Name: ____ Date: ___________________

Skin Disease History: (Please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratosis	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/Allergies	Basal Cell Skin Cancer
Blistering Sunburns	Melanoma	Poison Ivy
Dry Skin	Precancerous Moles	None

Other: ____

Do you wear Sunscreen? Yes No

If yes, what SPF? _______________

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? ____

Medications: (Please list all medications)

____

____

____

____

Allergies: (Please list all allergies and reactions)

____

____

____

____

Social History: (Please circle all that apply)

Currently Smokes – Daily	Has never smokes
Currently Smokes – Not Daily	Has smoked in the past
Recreational Drug Use	Drinks Alcohol/Frequency____________
None	

Other: ____

Patient Name: ____ Date: ________________________

Medical History: Review of Systems

Circle yes or no if you have the following conditions CURRENTLY:

Allergy/Immunologic
☐ **Yes** ☐ **No** Premedication prior to procedure
☐ **Yes** ☐ **No** Allergy to Adhesive
☐ **Yes** ☐ **No** Allergy to Topical Antibiotic Ointments
☐ **Yes** ☐ **No** Allergy to Lidocaine
Yes ☐ **No** Immunosupression
☐ **Yes** ☐ **No** Hay Fever
☐ **Yes** ☐ **No** Allergy to Latex

Integumentary/Skin
☐ **Yes** ☐ **No** Rash
☐ **Yes** ☐ **No** Changing Mole
☐ **Yes** ☐ **No** Problems with Healing
☐ **Yes** ☐ **No** Problems with Scarring (Keloid)

Hematology/Lymphatic
☐ **Yes** ☐ **No** Blood Thinners
☐ **Yes** ☐ **No** Problems with Bleeding

Endocrine
☐ **Yes** ☐ **No** Thyroid problems
☐ **Yes** ☐ **No** Are you Pregnant or Planning a Pregnancy
☐ **Yes** ☐ **No** Are you Currently Breastfeeding

Respiratory
☐ **Yes** ☐ **No** Wheezing
☐ **Yes** ☐ **No** Shortness of Breath
☐ **Yes** ☐ **No** Cough

Neurological
☐ **Yes** ☐ **No** Headaches
☐ **Yes** ☐ **No** Seizures

Eyes
☐ **Yes** ☐ **No** Blurry Vision

Cardiovascular
☐ **Yes** ☐ **No** Pacemaker
☐ **Yes** ☐ **No** Defibrillator
☐ **Yes** ☐ **No** Artificial Joints (past 2 years)
☐ **Yes** ☐ **No** Artificial Heart Valve
☐ **Yes** ☐ **No** Rapid Heart Beat with Epinephrine
☐ **Yes** ☐ **No** Chest Pain

Gastrointestinal (G.I.)
☐ **Yes** ☐ **No** Abdominal Pain
☐ **Yes** ☐ **No** Bloody Stool
☐ **Yes** ☐ **No** GI Upset with Antibiotics

Musculoskeletal
☐ **Yes** ☐ **No** Joint Aches
☐ **Yes** ☐ **No** Neck Stiffness
☐ **Yes** ☐ **No** Muscle Weakness

Psychiatric
☐ **Yes** ☐ **No** Anxiety
☐ **Yes** ☐ **No** Depression

Constitutional/Symptom
☐ **Yes** ☐ **No** Swollen Lymph Nodes
☐ **Yes** ☐ **No** Yeast Infections with antibiotics
☐ **Yes** ☐ **No** Unintentional Weight Loss
☐ **Yes** ☐ **No** Fever or Chills
☐ **Yes** ☐ **No** Night Sweats

Genitourinary
☐ **Yes** ☐ **No** Bloody Urine

ENT and Mouth
☐ **Yes** ☐ **No** Sore Throat