The Skin Clinic

SKIN PHYSICIANS & SURGEONS

Date _____

Patient Information (Please Print with Black or Blue ink only)

First _____ Middle _____ Last _____

Mailing Address _____

City _____

State _____ Zip _____

Social Security # _____

Gender: ❍ Female ❍ Male

Birth Date (mm/dd/yyyy)_____Age_____

Height_____Weight_____

Marital Status: ❍ Single ❍ Married ❍ Other

Phone

Home Phone _____

Work Phone _____

Cell Phone _____

Would you like a reminder by text message

❍ **yes** ❍ **no**

E-mail_____

Race:_____Language: _____

Ethnicity: _____

Spouse's Name_____DOB:_____Social Security #_____

Reason for Today's Visit _____

Emergency Contact Information

First _____ Last_____

Home Phone _____Cell Phone_____ Relation_____

Guarantor / Responsible party for minor child

Last Name _____First Name _____ MI _____

Address: _____ City_____ State_____Zip _____

Home Phone _____ Cell Phone _____SSN _____

Date of Birth_____/_____ / _____ Sex: ❍ M ❍ F

Guarantor Employment Information (if minor put responsible party employment)

Employment Status ❍ Full Time ❍ Part TIme ❍ Student ❍ Retired ❍ Other

Occupation _____

Company or School_____

Address _____

City _____ State_____Zip_____

INSURANCE INFORMATION (Please present insurance card(s) to the receptionist so that copies may be made)

Primary Insurance Name _____

Name of Policy Holder_____

Insured's ID# _____

Group # _____

Employer Name_____

Policy Holder's DOB _____

Gender ❍ Male ❍ Female

Policy Holder's Social Security #_____

Relationship of Patient to the Insured _____

Secondary Insurance Name _____

Name of Policy Holder _____

Insured's ID# _____

Group # _____

Employer Name _____

Policy Holder's DOB_____

Gender ❍ Male ❍ Female

Policy Holder's Social Security # _____

Relationship of Patient to the Insured _____

— Go To Page 2 —

Patient Past Medical History

Medical History	Yes	No	Details
Arthritis	❍	❍	
Artificial joint(s)	❍	❍	
Asthma	❍	❍	
Bladder	❍	❍	
Bleeding Disorder	❍	❍	
Breast Cancer	❍	❍	
Bronchitis	❍	❍	
Cancer	❍	❍	
Chest Pain/tightness	❍	❍	
Diabetes	❍	❍	
Emphysema	❍	❍	
Heart Disease	❍	❍	
Heart Murmur	❍	❍	
Hepatitis	❍	❍	
High Blood Pressure	❍	❍	
Kidney Stones	❍	❍	
Pacemaker	❍	❍	
Seizures	❍	❍	
Stroke	❍	❍	
Thyroid Disorder	❍	❍	
Tuberculosis	❍	❍	
Ulcers	❍	❍	
Xray Therapy	❍	❍	

Female Questions

Are you pregnant?	❍ Yes	❍ No	❍ N/A
Have you had a tubal or hysterectomy?	❍ Yes	❍ No	❍ N/A
Are you nursing?	❍ Yes	❍ No	❍ N/A

Patient Past Surgeries/Hospitalizations (if none, please type NONE)

	Surgery/Hospitalization	Date	Anesthesia complications	Notes
1				
2				
3				
4				
5				
6				

Skin History

	Yes	No	- Previous Treatments -	Notes
- No significant skin history	❍	❍		
Actinic Keratosis	❍	❍		
Basal Cell Carcinoma	❍	❍		
Eczema	❍	❍		
Malignant Melanoma	❍	❍		
Other Suspicious Lesion	❍	❍		
Psoriasis	❍	❍		
Squamous Cell Carcinoma	❍	❍		
Urticaria	❍	❍		

Skin Questions

When you are exposed to sun do you:	❍ Tan Only	❍ Tan & Burn
Has anyone in your family had skin cancer?	❍ Yes	❍ No
Do you have a history of any specific skin diseases?	❍ Yes	❍ No

— Go To Page 3 —

Patient Family History

	Yes	No	Afflicted Family Member	Notes
Family History	❍	❍		
Abnormal Bleeding	❍	❍		
Abnormal Clotting	❍	❍		
Adopted	❍	❍		
Autoimmune Disorders	❍	❍		
Brain Tumor	❍	❍		
Breast Cancer	❍	❍		
Diabetes	❍	❍		
Endocrine Disease	❍	❍		
Heart Disease	❍	❍		
Hemophilia	❍	❍		
High Blood Pressure	❍	❍		
Kidney Disease	❍	❍		
Liver Disease	❍	❍		
Lung Cancer	❍	❍		
Malignant Melanoma	❍	❍		
Other Cancer	❍	❍		
Ovarian Cancer	❍	❍		
Prostate Cancer	❍	❍		
Skin Cancer	❍	❍		
Skin Disease	❍	❍		

Patient Allergies (if none, please type none) **If list please give to receptionist**

	Allergy	Reaction	Notes
1			
2			
3			
4			

Patient Current Medications (if none, please type none)

	Drug	Dosage	Prescribed by
1			
2			
3			
4			
5			
6			

Patient Social History

ALCOHOL
- ❍ no alcohol use
- ❍ yes alcohol use socially
- ❍ yes alcohol use daily

ILLEGAL DRUGS
- ❍ no using illegal drugs
- ❍ yes using illegal drugs

STD
- ❍ no STD history
- ❍ yes STD history

HIV / AIDS
- ❍ no HIV/AIDS history
- ❍ yes HIV/AIDS history

Patient Smoking History

Current: _____

Former: Started_____ Ended_____

Never Smoker:_____

Vaccine Record

	Yes	No	
Influenza (flu shot)	❍	❍	Date_____
Pneumonia vaccine	❍	❍	Date_____

— Go To Page 4 —

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, The Skin Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Skin Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. The Skin Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Skin Clinic, Attention: Privacy Officer at 2410 N. Commerce, Ardmore, OK 73401. With my consent, the staff of The Skin Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, The Skin Clinic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that The Skin Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to The Skin Clinic's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Skin Clinic may decline to provide treatment to me.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Print Name of Patient	Print Name of Legal Guardian
Signature of Patient or Legal Guardian	Date

Payment Agreement

I understand and agree that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to **The Skin Clinic.**

Signature of Patient or Guardian