Dermatology Practice of the Carolinas, PA

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CHART # ______________

Patient Information

Name ____ Age ______________ Date of Birth___/___/____

SS#_____-____-______ Sex: M F Marital Status ______________ Email _________________________________

Mailing Address: ____

Phone: Home (____)______-_________ Work (____)______-__________ Cell (____)______-___________

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name of Insured ______________________________ Relationship to patient ________________________________

SS#_____-____-______ Date of Birth (of insured) ____/____/______

Mailing Address: ____

Phone: Home (____)______-_________ Work (____)______-__________ Cell (____)______-___________

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____________________________ Policy Holder's Name _____________________________

SS #_____-____-______ Birthdate: ____/____/______

Group #____ Contract # ____________________________

Employer Name __________________________________ Employer Phone ___________________________________

Relationship of patient to the Insured __________________ **Do you have Secondary Insurance?__________________

____

PHARMACY INFORMATION

Preferred Pharmacy Name ___________________________________

Address and Phone Number ____

In case of Emergency, who should be notified (other than those already listed above)?

Name ________________________________ Phone ____________________ Relationship __________________

All of the above is correct to the best of my knowledge, and I agree to notify this office in a timely manner of any changes.

Patient or Responsible Party Signature ______________________________________ **Date** ___/___/20____

Dermatology Practice of the Carolinas
History and Intake Form

Patient: ______________________ **DOB:** ____________ **Today's Date:** __________

Reason for today's visit: ____

Past Medical History: (please check all that apply)

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

Other ____

Past Surgical History: (please check all that apply)

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

Other ____

Skin Disease History: (please check all that apply)

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

Other ____

Do you wear Sunscreen?
If yes, what SPF? __________ Yes No

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 enter all current medications)

____

____

Allergies: (Please enter all allergies and associated reactions)

____

____

Social History: (Please check all that apply)

Currently Smokes - daily
Currently Smokes - not daily
Has smoked in the past
Has never smoked

Alcohol - < 1 drink daily
Alcohol - 1-2 drinks daily
Alcohol - ≥ 3 drinks daily
Alcohol - none

Drug Use
None
Other ____________________

Review of Systems: Are you currently experiencing any of the following?
(please check yes or no for the following)

Symptom	Yes	No
history of melanoma		
pacemaker		
defibrillator		
artificial joints within past two years		
artificial heart valve		
premedication prior to procedures		
allergy to adhesive		
allergy to topical antibiotic ointments		
blood thinners		
pregnancy or planning a pregnancy		
breastfeeding or lactation		
allergy to lidocaine		
rapid heart beat with epinephrine		
problems with bleeding		
problems with healing		
problems with scarring (hypertrophic or keloid)		
yeast infections with antibiotics		
GI upset with antibiotics		
fainting		
immunosuppression		
changing mole		
rash		
hay fever		
wheezing		

Other Symptoms:

____

____

____

Dermatology Practice of the Carolinas

Authorization for Release of Information to Family and/or Friends

Patient:__________________________________ DOB:________________________

Dermatology of the Carolinas is authorized to release protected health information about the above-named patient to the entities named below:

Entity to Receive Information. INITIAL EACH that is subject to this authorization.

______ Leave Information on the voice mail ▫ Home ▫ Cell ▫ Work

______ Give Information to spouse

______ Give information to the following person(s): ____________________________________

Type of Information to share with above.

_____ Financial Information

_____ Family billing information

_____ Information results from test or X-rays

_____ Medical information as follows: ____

_____ Other information described: ____

Rights of the Patient

I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in the document by signing a written notification to Dermatology Practice of the Carolinas. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

____________________________________ ________________

Signature of Patient or Personal Representative Date

____

Printed Name Patient or Representative