\_\_\_\_**New Patient**  \_\_\_\_\_\_**Update** **Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_

**Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:**  Male or Female **Age:** \_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ **Last Four (4) Digits of SS#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Apt #:** \_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**( Your Email will only be used for the patient portal)**

**Preferred Method of Contact for Reminder Calls:** Phone: \_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_

**Marital Status:** (circle one) Single Married Widowed Divorced

**Spouse’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Spouse’s Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_

**Other Family Members Seen in Our Office:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT:**

**Employer’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** #**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Spouse’s Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE BILLING**

PRIMARY INSURANCE SECONDARY INSURANCE

**Name of INS. Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name of INS. Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy Holder:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy Holder’s DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION OF PAYMENT:**

 I request that payment of authorized insurance benefits be made on my behalf to **Skin Envy Dermatology, Debra Baker, NP** for any services furnished to me. I authorize any holder of medical information to release to the Health Care Financing Administration or insurance company and its agents any information needed to determine these benefits or benefits for related services.

 I understand that I am responsible for all non-covered services under **Medicare** or any other **Insurance Plan** and I will pay at the time of services for all non-covered services, deductibles, and co-payments.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient or Legal Representative)

**EMERGENCY CONTACT:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (NAME) (PHONE NUMBER) (Relationship to you)

**CONSENT TO SHARE PATIENT INFORMATION:**

I wish the following individuals to have access to my private health information:

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Authorized Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about our office?**

**Friend\_\_\_\_\_\_\_ Billboard\_\_\_\_\_\_\_ Doctor\_\_\_\_\_\_\_ Radio\_\_\_\_\_\_\_ Social Media\_\_\_\_\_\_\_**

**HEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST OR PRESENT MEDICAL CONDITIONS: IF YOU HAVE EVER HAD THE FOLLOWING HEALTH PROBLEMS: PLEASE CHECK YES OR NO**

**YES NO YES NO**

\_\_\_\_ \_\_\_\_ BLEEDING PROBLEMS \_\_\_\_\_ \_\_\_\_\_ PACEMAKER

\_\_\_\_\_ \_\_\_\_\_ TAKING BLOOD THINNERS \_\_\_\_\_ \_\_\_\_\_ ARTIFICIAL HEART VALVE

\_\_\_\_\_ \_\_\_\_\_ HIV POSITIVE \_\_\_\_\_ \_\_\_\_\_ ARTIFICIAL JOINT REPLACEMENT

\_\_\_\_\_ \_\_\_\_\_ HEPATITIS B \_\_\_\_\_ \_\_\_\_\_ HEPATITIS C

\_\_\_\_\_ \_\_\_\_\_ HEART DISEASE \_\_\_\_\_ \_\_\_\_\_ HIGH CHOLESTEROL

\_\_\_\_\_ \_\_\_\_\_ HYPERTENSION \_\_\_\_\_ \_\_\_\_\_ CORONARY HEART DISEASE

\_\_\_\_\_ \_\_\_\_\_ DIABETES \_\_\_\_\_ \_\_\_\_\_ CONGESTIVE HEART FAILURE

\_\_\_\_\_ \_\_\_\_\_ CANCER (BREAST, PROSTATE, COLON) \_\_\_\_\_ \_\_\_\_\_ ASTHMA

\_\_\_\_\_ \_\_\_\_\_ THYROID DISEASE \_\_\_\_\_ \_\_\_\_\_ PREGNANT OR TRYING

\_\_\_\_\_ \_\_\_\_\_ SEASONAL /ENVIROMENTAL ALLERGIES \_\_\_\_\_ \_\_\_\_\_ BREASTFEEDING

ANY OTHER DISEASE’S NOT LISTED**:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY CURRENT MEDICATIONS OR PROVIDE A COPY (PLEASE INCLUDE OVER THE COUNTER MEDICATIONS, VITAMINS, AND HERBALS):

LIST ALL DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN TYPE (PLEASE CIRCLE) Social History YES NO**

**I** Always burns, never tansDo you drink alcohol**? \_\_\_\_ \_\_\_\_**

II Always burns, tans less than average If yes how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

III Sometimes burns, tans average Do you smoke or chew? **\_\_\_\_ \_\_\_\_**

IV Rarely burns, tans with ease Do you vape?  **\_\_\_\_ \_\_\_\_**

V Moderately pigmented, always tans Do you use IV or illicit drugs**? \_\_\_\_ \_\_\_\_**

VI Deeply pigmented, never burns What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have been offered and/or received a copy of Skin Envy Dermatology’s Notice of Privacy Practices effective 8/07/18

**Name (please print)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**For patients 65 or older:** Have you received a pneumonia vaccination? YES or NO

Advance Care Planning**:** Do you have a health care proxy in the event you are unable to make your own medical decisions? YES or NO

Designee’s Name:
 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Designee’s phone number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have a Living Will: Yes or NO

Which statement best reflects your wishes on advance care recommendations?

\_\_\_\_\_\_\_ Do Not Intubate

\_\_\_\_\_\_\_ Do Not Resuscitate

\_\_\_\_\_\_\_ Full Cardiopulmonary Resuscitation

PAST OR PRESENT MEDICAL CONDITIONS. IF YOU HAVE EVER HAD THE FOLLOWING HEALTH

PROBLEMS PLEASE CHECK YES OR NO.

Do you use sunscreen? YES \_\_\_\_\_ NO\_\_\_\_\_

YES NO YES NO

\_\_\_\_ \_\_\_\_ ECZEMA \_\_\_\_ \_\_\_\_ FLAKING OR ITCHY SCALP

\_\_\_\_ \_\_\_\_ ACNE \_\_\_\_ \_\_\_\_ ACTINIC KERATOSIS

\_\_\_\_ \_\_\_\_ DRY SKIN \_\_\_\_ \_\_\_\_ POISON IVEY

\_\_\_\_ \_\_\_\_ PSORIASIS \_\_\_\_ \_\_\_\_ HISTORY OF MRSA

\_\_\_\_ \_\_\_\_ PRECANCEROUS \_\_\_\_ \_\_\_\_ HISTORY SQUAMOUS CELL

 MOLES SKIN CANCER

\_\_\_\_ \_\_\_\_ HISTORY OF BLISTERING \_\_\_\_ \_\_\_\_ HISTORY OF BASEL CELL

 SUNBURNS SKIN CANCER

\_\_\_\_ \_\_\_\_ HISTORY OF MELANOMA

IF YES, WHERE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YEAR OF DIAGNOSIS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO TREATED LESION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, What SPF? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you tan in a tanning bed? YES\_\_\_\_\_ NO\_\_\_\_\_

Do you have a **FAMILY** history of Melanoma? YES\_\_\_\_\_ NO\_\_\_\_\_

IF YES, which relative(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_