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

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

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

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

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

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

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

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

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

**Marital Status:** ⎕ Single ⎕ Married ⎕ Widowed ⎕ Divorced

**Emergency contact name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_**

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

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

**Smoking:** ⎕ Current smoker ⎕ Light smoker ⎕Former smoker ⎕ Never smoked

**Alcohol use:** ⎕ 3+ drinks/day ⎕ 1-2 drinks/day ⎕ Less than 1 drink/day ⎕ I do not drink

**CONSENT TO SHARE PATIENT INFORMATION**

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

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

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

**Patient or Authorized Representative**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE SECONDARY INSURANCE

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

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

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

**Employer’s name if insurance through an employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder’s last 4 digits of Social Security Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**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)

**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 8/10/20

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

(Patient or Legal Representative)

**CONSENT TO MEDICAL CARE**

I understand the procedures standard to the care of dermatology and consent to undergo dermatologic care including any necessary procedure. These procedures include, but are not limited to cryosurgery, shave and punch biopsies, surgical excisions, cosmetics, and any medically necessary procedures. I will be informed of potential risks/side effects PRIOR to the procedure.

**Print name of patient** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Print name of parent/guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of parent/guardian:** ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

**LIST ANY CURRENT MEDICATIONS (INCLUDE OVER THE COUNTER MEDICATIONS, VITAMINS, AND HERBALS):**

**If you have a list, please provide us with your list**

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

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

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

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

**PAST OR PRESENT MEDICAL CONDITIONS: HAVE EVER HAD THE FOLLOWING HEALTH PROBLEMS:** \_\_\_\_ BLEEDING PROBLEMS \_\_\_\_\_ PACEMAKER

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

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

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

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

\_\_\_\_\_ THYROID DISEASE \_\_\_\_\_ PREGNANT (CURRENTLY)

\_\_\_\_\_ SEASONAL /ENVIROMENTAL ALLERGIES \_\_\_\_\_ BREASTFEEDING (CURRENTLY)

ANY OTHER HEALTH CONDITIONS NOT LISTED**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Mark your skin type:

|  |  |  |
| --- | --- | --- |
| ⎕Always burns, never tans | ⎕ Sometimes burns, tans average | ⎕ Moderately pigmented, always tans |
| ⎕ Always burns, tans less than average | ⎕ Rarely burns, tans with ease | ⎕ Deeply pigmented, never burns |

Skin Disease History: Please **check all** that apply:

\_\_\_\_ ACNE \_\_\_\_\_ ECZEMA

\_\_\_\_\_ ACTINIC KERATOSIS \_\_\_\_\_ FLAKING OR ITCHY SCALP OR SKIN

\_\_\_\_\_ ASTHMA \_\_\_\_\_ HAY FEVER/ALLERGIES

\_\_\_\_\_ BLISTERING SUNBURNS \_\_\_\_\_ POISON IVY

\_\_\_\_\_ BOILS/ABSCESS \_\_\_\_\_ PRECANCEROUS MOLES

\_\_\_\_\_ DRY SKIN \_\_\_\_\_ PSORIASIS

**Personal history of skin cancer?**

\_\_\_\_\_\_Basal Cell Carcinoma \_\_\_\_\_\_ Squamous Cell Carcinoma \_\_\_\_\_ Melanoma

If yes to any of these, please list location and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history of Melanoma?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANY OTHER HEALTH CONDITIONS NOT LISTED**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*ONLY ANSWER IF YOU ARE 65 YEARS OF AGE OR OLDER\*:**

Have you received a pneumonia vaccination? ⎕ YES ⎕ NO

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

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

Do you have a Living Will: ⎕ Yes ⎕ NO

Which statement best reflects your wishes on advance care recommendations?

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

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

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