

Date: _____

PATIENT INFORMATION

PATIENT: _____

Last Name

First Name

Middle Initial

"Preferred Name"

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Business Phone: _____ Cell: _____

Sex: M F Age _____ Date of Birth: _____ Social Security #: _____

Marital Status: Married Single Divorced Widowed Email: _____

Race: White American Indian
 Black/African American Asian
 Native Hawaiian/Pacific Islander Other Preferred Language: _____

Ethnicity: Hispanic Latino origin Non-Hispanic or Latino origin

PREFERRED PHARMACY: _____ Location: _____

EMPLOYER: _____ Occupation: _____

Whom may we thank for referring you? Doctor (name: _____) Family: _____ Other

RESPONSIBLE PARTY (if under 18): _____ Relationship to Patient: _____

SS#: _____ Date of Birth: _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE:** _____

Subscriber Name: _____ Subscriber Name: _____

Date of Birth: _____ SS#: _____ Date of Birth: _____ SS#: _____

Policy Number: _____ Policy Number: _____

MEDICARE PATIENTS ONLY

Forest Dermatology, PA accepts what is allowed and approved by Medicare.
Your co-payment and yearly deductible are your responsibility.

I request that payment of authorized Medicare benefits be made on my behalf to Forest Dermatology, PA for any services furnished me by that physician/supplier.

Signature: _____ Date: _____

MEDICAL HISTORY

(This is confidential medical information)

Have you ever had any of the following? (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Janudice,
Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS or HIV |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Immunosuppressive
Disorders |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Allergies to Anesthetics* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves
or Joints | <input type="checkbox"/> Allergies to Medicine
or Drugs* | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease or STDs |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol or Drug Abuse |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Special Diet | |
| <input type="checkbox"/> Asthma | | |

*Allergies to Medications (including local anesthetics): _____

Type of reaction (e.g., hives, swelling, etc.): _____

Reason for your visit today: _____

Check all that apply:

Previous Skin Disorders/Problems: _____

Skin Cancer? Yes No (Describe: _____)

Skin problems of other family members: _____

Other medical problem(s) being treated for: _____

List all medications you are currently taking: _____

List all herbal supplements/vitamins you are currently taking: _____

Have you ever been advised by other physicians to take antibiotics before having dental procedures? _____

WOMEN ONLY

Are you pregnant? _____ Do you plan on becoming pregnant in the near future? _____

Are you taking birth control? _____ In what form? _____

PATIENT INFORMATION CONSENT FORM

I have read and understand **Forest Dermatology's** Notice of Information Practices. I understand that **Forest Dermatology** will use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and/or any administrative operations related to treatment. I understand that I have the right to restrict how my PHI is used for treatment, payment, or administrative operations if I notify the practice of my wishes. I understand that **Forest Dermatology** will consider requests for restrictions on a case-by-case basis, but is not legally bound to agree to requests for restrictions.

I have read and understand that **Forest Dermatology** does not allow the use of PHI for the purposes for marketing, fund raising, solicitation, or for research studies.

I hereby consent to the use and disclosure of my personal health information for the provision of treatment, facilitation of payment, evaluation of service quality, or administrative operations.

Designated Individuals Authorization

I hereby authorize the persons listed below to request and receive any personal health information regarding my treatment, payment, or administrative operations. I understand that the identity of the designated parties must be verified prior to the release of any information.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Communication from Forest Dermatology

Messages from Forest Dermatology may be left for me at the following location(s):

Home: _____ Work: _____ Cell: _____

- I have read and understand Forest Dermatology, PA's "Notice of Privacy Practices" and Financial Policy.
- I authorize release of medical information to authorized parties.

Patient Name _____

Signature: _____

Date: _____