PROVIDENCE DERMATOLOGY

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ALL INFORMATION WILL BE KEPT CONFIDENTIAL, PLEASE PRINT AND COMPLETE ALL ITEMS FULLY

PATIENT INFORMATION

PATIENT NAME: _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

MAILING ADDRESS: _____
STREET/APT.# CITY STATE ZIP CODE

PHONE: _____ [ ] Home [ ] Work [ ] Cell **EMAIL:** _____

MARITAL STATUS: [ ] Single [ ] Married [ ] Widow [ ] Divorced **GENDER AT BIRTH:** [ ] Male [ ] Female

RACE: [ ] Asian [ ] Black/African [ ] Caucasian [ ] Hispanic/Latino [ ] Native American [ ] Pacific Islander

PHYSICIAN WHO SENT YOU : _____ PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____
NAME RELATIONSHIP PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____ SUBSCRIBER'S ID: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____
FIRST MIDDLE LAST

MAILING ADDRESS: _____ GENDER: [ ] Male [ ] Female
STREET/APT. CITY STATE ZIP CODE

PHONE: _____ PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY: _____

SECONDARY INSURANCE COMPANY: _____ SUBSCRIBER'S ID: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____
FIRST MIDDLE LAST

MAILING ADDRESS: _____ GENDER: [ ] Male [ ] Female
STREET/APT. CITY STATE ZIP CODE

PHONE: _____ PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY: _____

GUARANTOR : _____ **DATE OF BIRTH:** _____ **[ ] CHECK HERE IF UNINSURED (SELF PAY)**

MEDICARE PATIENTS ONLY
I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____
PATIENT OR PATIENT'S REPRESENTATIVE SIGNATURE DATE

RELEASE OF MEDICAL INFORMATION

By signing below, I authorize **Dr. Maughan, Dr. James, Heather Allred PA-C and Providence Dermatology** to disclose my protected health information, including, but not limited to office notes, diagnostic tests, and lab results, to the below named persons (e.g. spouse, parent). This authorization shall be effective until revoked in writing.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

REASON FOR YOUR VISIT TODAY:_____

HOW LONG HAVE YOU HAD THIS PROBLEM?:_____

SYMPTOMS:_____ TREATMENTS YOU HAVE TRIED:_____

MEDICAL HISTORY

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING?

[ ] Allergy symptoms	[ ] Dryness	[ ] Itching	[ ] Recurrent infection
[ ] Blisters	[ ] Fever	[ ] Keloid	[ ] Suspicious lesion
[ ] Bruising	[ ] Hives	[ ] Rash	[ ] Weight change

HAVE YOU HAD SKIN CANCER: [ ] Yes [ ] No

IF YES, [ ] Melanoma [ ] Basal Cell Carcinoma [ ] Squamous Cell Carcinoma [ ] Yes, but don't know type

LOCATIONS?:_____

DO YOU HAVE ANY FAMILY HISTORY OF SKIN CANCER: [ ] Yes [ ] No

IF YES, WHO AND WHAT TYPE:_____

CHECK BELOW IF YOU HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES:

GENERAL

[ ] Artificial heart valves	[ ] Diabetes mellitus 1	[ ] Liver disease
[ ] Artificial joints	[ ] Diabetes mellitus 2	[ ] Lung disease
[ ] Asthma	[ ] Epilepsy	[ ] Mental / Anxiety disorder
[ ] Bleeding disorder	[ ] Hay fever	[ ] Pacemaker
[ ] Blood clots	[ ] Heart disease	[ ] Seasonal allergies
[ ] Cancer _____	[ ] Hepatitis A-B-C	[ ] Stroke
[ ] Depression	[ ] High Blood Pressure	[ ] Thyroid Disease
[ ] Dementia	[ ] Kidney disease	[ ] Other _____

SKIN

[ ] Acne	[ ] Hives
[ ] Actinic keratoses	[ ] Itching
[ ] Alopecia/Hair loss	[ ] Psoriasis
[ ] Dermatitis	[ ] Rosacea
[ ] Dysplastic mole	[ ] Scabies
[ ] Eczema	[ ] Shingles
[ ] Genital Warts	[ ] Vitiligo
[ ] Herpes	[ ] Warts

PLEASE LIST ANY SURGERIES YOU PREVIOUSLY HAVE HAD IN THE LAST 2 YEARS:_____

MEDICATIONS

LIST **ALL** THE MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS AND OVER-THE-COUNTER MEDICINES)

_____

ALLERGIES

HAVE YOU EVER HAD AN ALLERGIC REACTION TO (CIRCLE): **LATEX / LIDOCAINE / EPINEPHRINE / IODINE / ADHESIVES**

PLEASE LIST ANY MEDICATIONS/PRODUCTS YOU ARE ALLERGIC TO:_____

OTHER

FORMER SMOKER: [ ]YES [ ]NO TOBACCO USE: [ ]YES [ ]NO ALCOHOL USE: [ ]YES [ ]NO

FEMALE PATIENTS ONLY

ARE YOU PREGNANT? [ ] YES [ ] NO ARE YOU BREASTFEEDING? [ ] YES [ ] NO ARE YOU TRYING TO CONCEIVE? [ ] YES [ ] NO

FINANCIAL POLICY & ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I authorize payment of Insurance benefits, otherwise payable to me, directly to **Providence Dermatology**. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents, even if services are deemed as *non-medially necessary" by my insurance carrier. **I understand co-payments are due at the time of service.** I am responsible for providing correct/updated insurance so this office can bill my insurance. I authorize **Providence Dermatology** to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that payment in full for charges are not made, I agree to pay for all costs of collection including a collection fee and court costs.

_____

PATIENT OR PATIENT'S REPRESENTATIVE SIGNATURE DATE