Paladin Dermatology

## PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

DOB: _____ Sex: ____ Marital Status: _____ Social Security #:_____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

**Please Circle Preferred Method of Contact**

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer / School: _____ E-Mail: _____

Primary Care Physician: _____ Phone: _____

## RESPONSIBLE PARTY (Please complete if patient is under the age of 18)

Relationship to Patient: _____ Name: _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

DOB: _____ SSN: _____ Employer: _____

## EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

Address, City, State, Zip: _____

## How did you hear about Paladin Dermatology

Physician Referral _____ Word of Mouth _____ Internet _____ Newspaper / Magazine _____
Drove by our Clinic _____ Health Fair _____ Direct mail _____ Insurance Co _____ Other _____

## PHOTOGRAPHS

I authorize Paladin Dermatology to take photos that may be requested during treatment. Any photograph taken will be used for treatment and educational purposes with the appropriate privacy.

☐ YES ☐ NO

## FINANCIAL POLICY

I have read and understand the terms of the Paladin Dermatology Financial Policy. I have also been offered a copy of this financial policy.

_____ _____
Signature of Patient / Guardian Date

Paladin Dermatology

****PLEASE NOTE****

We are glad to file insurance for you and will do so in a timely manner. However, to do so, the following information needs to be given in its entirety. Incomplete information will result in us not being able to file your insurance claim and you will be given the option to either pay in full for services rendered on the day of your visit or to reschedule your appointment.

## INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Primary Cardholder's Name: _____ DOB: _____

Relationship to Patient: ___ Self ____Spouse ____ Dependent

Secondary Insurance: _____ Policy #: _____ Group#: _____

Secondary Cardholder Name: _____ DOB: _____

Secondary Cardholder Relationship to Patient: ___ Self ____Spouse ____ Dependent

**If Separate Rx Plan:**

Rx Plan Name: _____ Phone: _____

Rx Plan ID Number: _____

## Authorization for Release of Information

**Release of Medical Information**

Do we have your permission to discuss any medical condition or treatments, and/or leave a message with a family member/ member of your household /friend/other? _____ **YES (Please List)** _____ **NO**

NAME: _____ Relationship: _____ Phone: _____

☐ Results of Lab/Other Tests ☐ Financial information ☐ Other information: _____

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I hereby give my consent for Paladin Dermatology to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations. I have received and read the **NOTICE OF PRIVACY PRACTICES** prior to signing this consent.

_____ _____

**Patient Signature** **Date.**

**Patient Name:** _____

Preferred Pharmacy: _____ City: _____ Phone: _____

# PATIENT HISTORY

**Do you have or have you ever had the following** (please circle):

| | | | | |
|---|---|---|---|---|
| HIV/AIDS | Defibrillator | Anxiety | Hearing Loss | Hepatitis B or C |
| Pacemaker | Arthritis | Asthma | Tuberculosis | High Blood Pressure |
| Diabetes | Depression | Kidney Disease | Liver Disease | Mitral Valve Prolapse |
| Inflammatory Bowel Disease | | Coronary Artery Disease | | Hyper-/Hypo- Thyroidism |

Internal Cancer of: _____ Other: _____

**Past Surgical History** (please circle):

| | | |
|---|---|---|
| Appendix | Coronary Artery Bypass Surgery | Joint Replacement: Knee Hip Shoulder |
| Tonsils | Heart Valve Replacement | Organ Transplant: Heart Kidney Liver |
| Cancer | Hysterectomy | Other: _____ |
| Colon Resection | Gallbladder (Cholecystectomy) | _____ |

**Medications** (please list): _____

_____

_____

_____

**Do you take any blood thinners:** None Aspirin Coumadin Plavix Other: _____

**Medication allergies:** _____

**Other allergies** (please circle): Latex Tape Neosporin Other: _____

**Have you ever been Diagnosed with Psoriasis?** Yes No **Eczema?** Yes No

**Have you ever had skin cancer**: Yes No If Yes, what type: _____

**Please list any blood relatives with a history of skin cancer (Melanoma):**_____ **Type:** _____

**Do you use tobacco products**: Never Yes Quit **Breastfeeding**: Yes No

**Are you Pregnant**: Yes No **Do you drink alcohol**: Yes No

**Have you ever received the Pneumonia Vaccine?** Yes No

**Have you received the Flu Vaccine this year?** Yes No