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: ______________________________

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

<u>If Separate Rx Plan:</u>

Rx Plan Name: ___________________________________ Phone: _________________________________

Rx Plan ID Number: _______________________________

Authorization for Release of Information

<u>Release of Medical Information</u>

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: ____ DOB:__________________

Preferred Pharmacy (Name, Address, Phone): ____

Primary Care Physician / Practice: _________________________________ **Phone:** ________________

Medical Conditions: **Do you have or have you ever had the following** (check the applicable boxes):

Anxiety	Coronary Artery Disease	HIV/AIDS	Pacemaker
Arthritis	Defibrillator	Hyperthyroidism	Radiation Treatment
Artificial Heart Valve	Depression	Hypothyroidism	Stroke / TIA
Asthma	Diabetes	Inflammatory Bowel Disease	Seizures
Bleeding/Clotting Disorder	Hearing Loss	Internal Cancer of:_________ ________________________	Tuberculosis
Bone Marrow Transplant	Hepatitis B or C	Kidney Disease if so, Hemodialysis Peritoneal Dialysis	Viral Infections (Herpes, Cold Sores, Shingles, etc)
Chemotherapy	High Blood Pressure	Liver Disease	**Other:**
COPD/Emphysema	High Cholesterol	Mitral Valve Prolapse	

Past Surgical History (please check the applicable boxes):

Appendix	Gallbladder (Cholecystectomy)	Joint Replacement: Knee Hip Shoulder
Cancer	Heart Valve Replacement	Organ Transplant: Heart Kidney Liver
Colon Resection	Hysterectomy	Permanent Port or IV Line (chemo, feeding tube, dialysis, etc.)
Coronary Artery Bypass Surgery	MOHS Surgery	Tonsils
Other:		

MEDICATION:	DOSE:	HOW OFTEN:

1. **Do you take any blood thinners:** None Aspirin Coumadin Xarelto Plavix Other: ____________
2. **Have you received the Pneumonia Vaccine within the last 5 years?** Yes No
3. **Have you received the Flu Vaccine this year?** Yes No

ALLERGIES

4. **Medication allergies:** ____
____
5. **Other allergies** (please circle): Latex Tape Neosporin Other:
____

SKIN CANCER HISTORY & DERMATOLOGY CONDITIONS

6. **Have you ever been Diagnosed with Psoriasis?** Yes No **Eczema?** Yes No
7. **Have you ever had skin cancer**: Yes: (please specify location) No

   Melanoma: __________________ **Basal Cell**: ______________ **Squamous Cell:** ________________
8. **Please list any blood relatives with a history of skin cancer** (Please List Relation)

   Melanoma: ____________________ **Basal Cell:** _____________ **Squamous Cell:** _________________

SOCIAL

Do you use tobacco products: Never Yes Quit	**Currently Breastfeeding**: Yes No
Are you Pregnant: Yes No	**Do you drink alcohol**: Yes No