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.)

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

*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: page 2*)

Consent Form

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

____ Home ____Work ____Cell

2. List anyone with whom we may discuss your personal, medical or financial information (i.e. family members or friends.) I understand that the identity of these designated parties must be verified prior to the release of any information.

Name_____Relationship_____

Name_____Relationship_____

3. Emergency Contact:

Name_____Relationship_____

Phone 1_____Phone 2_____

4. Consent to Treat Minors (18 years old or younger)

I hereby authorize the person(s) listed below to bring my minor child to Forest Dermatology for diagnostic evaluation and treatment (other than parents):

_____ Relationship:
_____

_____ Relationship:
_____

5. Patient Information Consent

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 any administrative operations related to treatment, payment. 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 restriction on a case-by-case basis, but is not legally bound to agree to requests for restrictions.

I 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.

_____
Patient Name

_____
Signature

_____
Date