MIDTOWN DERMATOLOGY

PATIENT INFORMATION

Patient Legal Name (First)_____(MI)_____(Last)_____

Date of Birth: _____/_____/_____ Age: _____ SSN: _____

BIRTH GENDER: Male / Female GENDER IDENTITY: _____

MARITAL STATUS: Married / Divorced / Single Spouse's Name:_____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____

WORK PHONE: (_____)_____ OK TO LEAVE VOICEMAIL? YES / NO

EMAIL: _____

Are you employed? YES / NO Place of Employment: _____

Doctor who referred you? _____

Any other person who referred you? _____ Ethnicity: Hispanic / Non-Hispanic

Preferred Language: _____ Race: _____

EMERGENCY CONTACT INFORMATION AND/OR PARENT/GUARDIAN (IF PATIENT IS A MINOR)

Name: _____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The patient is responsible for all fees, regardless of insurance coverage.

Please READ and SIGN the following authorization assignment:

I hereby authorize Midtown Dermatology to furnish information to insurance carriers concerning my diagnoses and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any charges not covered by insurance.

Patient Signature: _____ **Date:** _____

A photocopy of the authorization and assignment shall be considered as valid as the original.

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HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Reason for Today's Visit: _____

PAST MEDICAL HISTORY (Do you have or have you ever had the following? Check if YES)

____ None
____ Anxiety
____ Arthritis
____ Asthma
____ Atrial fibrillation (Irregular heartbeat)
____ BPH (Benign Prostatic Hyperplasia)
____ Cerebrovascular Accident (Stroke)
____ COPD
____ COVID-19
____ Coronary Artery Disease / Heart Attack
____ Depression
____ Diabetes
____ End Stage Kidney Disease
____ Epilepsy / Seizures
____ GERD
____ Hypertension (High Blood Pressure)
____ Hearing Loss
____ HIV / AIDS
____ High Cholesterol
____ Hyperthyroidism
____ Hypothyroidism
____ Hepatitis
____ Leukemia
____ Lymphoma
____ Lung Cancer
____ Breast Cancer
____ Colon Cancer
____ Prostate Cancer
____ Radiation Treatment

Other: _____

PAST SURGICAL HISTORY

____ None
____ Knee Replacement (Both / Right / Left)
____ Hip Replacement (Both / Right / Left)
____ Breast Biopsy
____ Prostate Biopsy
____ Coronary Artery Bypass Graft
____ Kidney Transplant
____ Appendectomy (appendix removal)
____ Mastectomy (Both / Right / Left)
____ Cholecystectomy (gall bladder removal)
____ Colectomy (removal of colon, partial or total)
____ Heart Valve Replacement (Tissue / Mechanical)
____ Cystectomy (bladder removal)
____ Hysterectomy (uterus removal)
____ Breast Lumpectomy (Both / Right / Left)
____ Oophorectomy (ovary removal)
____ Pancreatectomy (pancreas removal)
____ Kidney stone removal
____ Prostatectomy (prostate removal)
____ Splenectomy (spleen removal)
____ Nephrectomy (kidney removal)
____ Orchiectory (testicle removal)
____ Heart transplant
____ Liver transplant

Other: _____

PAST SKIN HISTORY

____ None
____ Acne
____ Actinic Keratosis (pre-cancer)
____ Dry Skin
____ Basal Cell Carcinoma
____ Abnormal Mole(s)
____ Eczema
____ Melanoma
____ Itchy Scalp / Dandruff
____ Psoriasis
____ Squamous Cell Carcinoma
____ Severe Sunburn(s)

Do you have a family history of Melanoma? YES / NO If yes, which relative? _____

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CURRENT MEDICATIONS

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES TO MEDICATIONS: Yes / No

If yes, please list: _____

_____

Pharmacy Name: _____ Location (Cross Streets):_____

SOCIAL HISTORY

Smoking Status: ____ Never ____ Current ____Former

Do you drink alcohol? ____None ____< 1 drink per day ____1-2 drinks per day ____3+ drinks per day

Have you ever used recreational drugs? YES / NO

Have you ever used illicit drugs? YES / NO

Do you feel safe at home? YES / NO

For patients 65 years old or older:

Have you received the pneumonia vaccine? YES / NO

Do you have a health care proxy? YES / NO

Do you have a living will? YES / NO

FAMILY HISTORY

Do you have a family history of other types of cancer? YES / NO

If yes, what type and which relative?_____

Do you have any relevant family history you would like to inform us about? YES / NO

If yes, please specify:_____

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HIPAA PRIVACY AUTHORIZATION
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Patient Name: _____ **Date of Birth:** _____

Confidential Communication Request

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request that communication concerning your personal health be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, *(print your full name)* _____, hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment, or payment for services. **This request supersedes any prior request for confidential channel communication I may have made.**

Contact Information:

Home #: _____ ☐ Do ☐ Do Not Leave messages on my voicemail

Cell #: _____ ☐ Do ☐ Do Not Leave messages on my voicemail

☐ Do ☐ Do Not Send text messages (appointment reminders)

Work #: _____ ☐ Do ☐ Do Not Leave messages on my voicemail

☐ Do ☐ Do Not Leave message with any other person

Email: _____ (appointment reminders)

Please list other persons that may be contacted with confidential communications:

Name: _____ Relationship to patient: _____ Phone #:_____

Name: _____ Relationship to patient: _____ Phone #:_____

Name: _____ Relationship to patient: _____ Phone #:_____

By signing this form, I acknowledge that I have received a copy of Midtown Dermatology's Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

If not signed by the patient, please indicate the relationship:
____*Parent/Guardian of a minor*
____*Guardian or conservator of an incompetent patient*
____*Beneficiary or personal representative of a deceased patient*
____*Other (specify):* _____