

PLEASE PRINT

Patient's Name _____

Address _____

City/State/Zip _____

Billing address if different than above _____

Date of Birth ____/____/____ Social Security Number ____-____-____

Sex _____ Marital Status: ____single ____married ____widowed ____other

Phone: Home(____) _____ Cell (____) _____ Work(____) _____

Email address _____

Patient's Employer _____ Employer phone _____

If minor, name of Legal Guardian _____

IN CASE OF EMERGENCY NOTIFY _____ PHONE _____

Primary Care Physician(name) _____ Referred By _____

Address _____ Phone # _____

Please present insurance card(s) and photo ID to the receptionist so copies may be made

Primary Insurance _____

Name of Primary Insurance Holder _____

Primary Insurance Holder: Date of Birth ____/____/____ Social Security ____-____-____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required from you at the time of service for "your part" of the charges.

I give permission to the doctor and staff to leave a message on my answering machine ___Y___N

I give permission to the doctor and staff to call me at work ___Y___N

I give permission to the doctor and staff to discuss my medical condition with:
my family ___Y___N other healthcare providers ___Y___N

Signature _____ Date _____

Date _____

Name _____

Please answer the following questions:

FAMILY HISTORY:

If anyone in your family has had any of these diseases please list family member:

Melanoma _____ Psoriasis _____ Eczema _____

Other skin cancer _____ Season Allergies _____ Other _____

SOCIAL HISTORY:

What is your occupation? (if retired, list past occupation) _____

Do you use tobacco? ___ Yes ___ No Do you drink alcohol? ___ frequently ___ occasionally ___ never

REVIEW OF SYSTEMS:

Please check any of the following problems that you have or have had:

SKIN ___ keloids ___ poor healing ___ rash ___ other _____	HEMATOLOGIC/ LYMPHATIC ___ anemia ___ bleeding problems ___ enlarged lymph nodes	CONSTITUT. SYMPTOMS ___ weight loss ___ fever ___ weak, tired	EARS/EYES/NOSE THROAT ___ glaucoma ___ hearing aid ___ cosmetic surgery
CARDIOVASCULAR ___ angina, heart attacks ___ heart valve problems ___ pacemaker ___ high blood pressure	RESPIRATORY ___ asthma ___ emphysema ___ other lung problems ___ allergies	PSYCHIATRIC ___ depression ___ anxiety attacks ___ other _____	MUSCULOSKELETAL ___ arthritis ___ artificial joints ___ aching joints
NEUROLOGICAL ___ stroke ___ seizures ___ headaches ___ dizziness	GASTROINTESTINAL ___ stomach ulcers ___ colitis ___ other GI problems	INFECTIONS ___ hepatitis ___ HIV/AIDS ___ TB ___ urinary tract	ENDOCRINE ___ diabetes ___ thyroid problems ___ other _____

CANCER: ___ skin ___ lung ___ breast ___ colon ___ other _____

MEDICATIONS: _____

Consent to Release Personal Health Information
and Acknowledgement of Receipt of Notice of Privacy Practices
of Academic Dermatology Associates, LLC

Academic Dermatology Associates, LLC reserves the right to modify the privacy practices outlined in the notice.

I, individually or on behalf of the patient, authorize Academic Dermatology Associates, LLC to use and disclose my health information as required for treatment, payment and healthcare operations as described in Academic Dermatology Associates, LLC's Notice of Privacy Practices.

I hereby acknowledge that I was given a copy of Academic Dermatology Associates, LLC's Notice of Privacy Practices on the date written below.

Name of Patient (PRINT)

Signature

Date

If signed by personal representative, relationship to patient.

Office Use Only

If Academic Dermatology Associates, LLC is unable to obtain an acknowledgement of receipt of the Notice of Privacy Practices, explain why:

Academic Dermatology Associates, LLC's employee signature

Date

Patient Intake Form Meaningful Use Measures

*Our practice is now using an electronic health record called DrFirst RcopiaMU. We are participating in the meaningful use incentive program sponsored by the federal government. We are collecting this data to be compliant with the program in an effort to increase patient safety, improve patient care and create a complete patient record. We appreciate your assistance with providing our practice this information about your health information.**

*Please fill out completely and return to the Receptionist

Required Information	Please fill in information in the area below
Full Name	
Date of Birth	
Gender	
Race	Please indicate your race (circle); Other American Indian Asian Black or African American Native Hawaiian or Other Pacific Islander White Unable to Determine or Not Stated
Ethnicity	Please indicate your ethnicity (circle); Other Hispanic/Latino
Preferred Language	Please select your preferred language (circle); English Chinese Spanish Japanese French Italian Portuguese Russian Declined Unavailable(unknown) Other(Please Specify) _____
Smoking Status	Please select your current smoking status (circle); Current every day smoker Current some day smoker Former smoker - Please list date range you smoked _____ to _____ Never smoked Smoker, current status unknown Unknown if ever smoked
Height	
Weight	
Do you have allergies?	If yes, what are you allergic to?
Are you taking any medications?	If yes, which medications?
Pharmacy you use	