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	