

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

**Pharmacy Phone Number:** \_\_\_\_\_

**Reason(s) for Visit:** (chief complaint)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** (Check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> Coronary Artery Disease            | <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Depression                         | <input type="checkbox"/> Hyperthyroidism (Overactive Thyroid)    |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Hypothyroidism (Underactive Thyroid)    |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> End Stage Renal Disease            | <input type="checkbox"/> Leukemia                                |
| <input type="checkbox"/> Bone Marrow transplant                    | <input type="checkbox"/> GERD (Acid Reflux)                 | <input type="checkbox"/> Lymphoma                                |
| <input type="checkbox"/> BPH (Enlarged Prostate)                   | <input type="checkbox"/> Hearing Loss                       | <input type="checkbox"/> Nephrolithiasis (Kidney Stones)         |
| <input type="checkbox"/> Cancer: _____                             | <input type="checkbox"/> Hepatitis: _____                   | <input type="checkbox"/> Seizures                                |
| <input type="checkbox"/> Cholelithiasis (Gallstones)               | <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Stroke (CVA, TIA)                       |
| <input type="checkbox"/> COPD                                      | <input type="checkbox"/> HIV/AIDS                           | <input type="checkbox"/> <b>Other:</b> _____                     |

**Past Surgeries:** (Check all that apply)

**Appendix:**

Appendectomy

Mechanical Valve Replacement

Pacemaker

PTCA (cardiac stents)

**Bladder:**

Cystectomy (removal)

**Joint Replacement:**

Hip:  Right  Left

Knee:  Right  Left

**Breast:**

Lumpectomy:  Right  Left

Mastectomy:  Right  Left

**Kidney:**

Dialysis

Stone Removal

Transplant

Nephrectomy (removal)

**Colon:**

Colon Cancer Resection

Diverticulitis

Inflammatory Bowel Disease

Gallbladder Removal

**Liver:**

Hepatectomy

Transplant

Shunt

**Heart:**

Biological Valve Replacement

Coronary Artery Bypass Surgery (CABG)

Defibrillator

Heart Transplant

**Ovaries:**

Tubal Ligation

**Pancreas:**

Pancreatectomy (removal)

**Prostate:**

Prostatectomy (removal)

TURP

**Rectum:**

APR (abdominal perineal resection)

Low Anterior Resection

**Spleen:**

Splenectomy (removal)

**Testicles:**

Orchiectomy (removal)

**Uterus:**

Partial Hysterectomy

Total Hysterectomy

**Other:** \_\_\_\_\_

**Skin Disease:** (Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acne                 | <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Poison Ivy              |
| <input type="checkbox"/> Actinic Keratosis    | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Precancerous Moles      |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis               |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Hay Fever/Allergies    | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Blistering Sunburns  | <input type="checkbox"/> Melanoma               | <b>Other:</b> _____                              |

Do you wear sunscreen?  Yes  No If Yes what SPF? \_\_\_\_\_

Do you tan in a tanning salon?  Yes  No

**Medications:** Please list all medications that you are currently taking and their dosage including over the counter and vitamins

Medication(s) Name:	

**Allergies:** (Check all that apply)

- No Known Drug Allergies
- Adhesive
- Codeine
- Environmental Allergies: \_\_\_\_\_
- Food Allergy: \_\_\_\_\_
- Iodine
- IV/Contrast Dye

- Latex
- Lidocaine
- Penicillin
- Sulfa
- Topical antibiotic ointments

**Other:** \_\_\_\_\_

**Social History:** (Check all that apply)

**Smoking Status:**  Current  Former  Never

**Alcohol use:**  None  less than 1 drink per day  
 1-2 drinks per day  3 or more per day

**Family History:** (Check all that apply and write the family members relation; i.e. grandfather, grandmother, father, mother, sister, brother, son, daughter, aunt, uncle, niece, nephew)

- Adopted
- Non melanoma skin cancer: \_\_\_\_\_
- Melanoma: \_\_\_\_\_
- Asthma: \_\_\_\_\_
- Hay fever: \_\_\_\_\_

- Psoriasis: \_\_\_\_\_
- Eczema: \_\_\_\_\_
- Dermatitis: \_\_\_\_\_
- Allergies: \_\_\_\_\_

**Other:** \_\_\_\_\_

**Alerts:** (Check all that apply)

- Allergy to adhesive
- Allergy to latex
- Allergy to lidocaine
- Allergy to topical antibiotic ointments
- Artificial heart valve
- Artificial joints within past two years
- Blood thinners
- Defibrillator
- Hepatitis A
- Hepatitis B
- Hepatitis C
- History of Melanoma

- MRSA
- Pacemaker
- Premedication prior to procedures
- Rapid heartbeat with epinephrine
- Pregnancy or planning pregnancy

Patient/ Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**CONSENT FOR TREATMENT**

- A. I hereby request evaluation and treatment by a provider (physician, PA, or NP) of PREMIER DERMATOLOGY & COSMETIC SURGERY and/or their staff. This includes photographs needed for medical treatment and continuity of care.
- B. The patient/guarantor has the responsibility to inform PDCS if the patient's contact information changes, i.e. phone number, address, and email.
- C. I authorize payment of medical benefits for myself/dependent directly to PREMIER DERMATOLOGY & COSMETIC SURGERY for professional services.
- D. For all services rendered to minor patients, the adult accompanying the patient is responsible for any payment due at the time of service.
- E. I authorize the release of medical information necessary to process insurance claims.

X \_\_\_\_\_  
(Signature of patient OR Responsible Party if a Minor) (Date)

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**FOR MEDICARE PATIENTS ONLY:**

**Please sign below once or twice as applicable. You may complete insurance information or give cards to the receptionist to complete.**

I request that payment of authorized **Medicare** and/or insurance benefits be made either to me or on my behalf to PREMIER DERMATOLOGY & COSMETIC SURGERY for any services furnished me by said physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

X \_\_\_\_\_  
(SIGNATURE OF BENEFICIARY) (HIC CLAIM NUMBER)

\_\_\_\_\_  
(DATE)

**SECONDARY INSURANCE FOR MEDICARE PATIENTS**

I request that payment of authorized **Medigap** benefits be made either to me or on my behalf to PREMIER DERMATOLOGY & COSMETIC SURGERY. I authorize any holder of medical information about me to release to (below named **Medigap** insurer) any information needed to determine the benefits payable for related services.

X \_\_\_\_\_  
(SIGNATURE OF BENEFICIARY)

\_\_\_\_\_  
(MEDIGAP CARRIER)

\_\_\_\_\_  
(MEDIGAP ADDRESS)

\_\_\_\_\_  
(MEDIGAP POLICY NUMBER)

\_\_\_\_\_  
(MEDIGAP POLICY HOLDER)

## Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient or the legal guardian of a patient of Premier Dermatology & Cosmetic Surgery. I acknowledge receipt of Premier Dermatology & Cosmetic Surgery's Notice of Privacy Practices.

I grant permission for Premier Dermatology & Cosmetic Surgery to inform the following individual/individuals of any and all results pertaining to my medical history and/or care:

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Name Relationship

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Name Relationship

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Name Relationship

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Signature of Patient or Legal Guardian

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Print Patient's Name

---

Date

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Print Name of Legal Guardian