

Advanced Dermatology
Skin Cancer and Laser Surgery Center, P.C.
PATIENT HEALTH SUMMARY

The following information will be verified on each follow-up visit for the patient.

Patient's Name (PLEASE PRINT): _____
Date of Birth _____ Patient Age _____ Today's Date _____
Referring Physician: _____
Primary Care Physician: _____ Phone # _____
Reason for Today's Visit: _____

MEDICATION ALLERGIES:

CURRENT MEDICATIONS:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

MEDICAL HISTORY (Why you are taking the above medication. Example: Diabetes, Heart Disease, Depression, etc):

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Have you ever had a skin cancer?	YES / NO
Has anyone in your family ever had a skin cancer?	YES / NO / UNKNOWN
Has anyone in your family ever had asthma?	YES / NO / UNKNOWN
Has anyone in your family ever had hayfever?	YES / NO / UNKNOWN
If applicable, are you Pregnant or Breast feeding?	Pregnant (YES / NO) Breast Feeding (YES / NO)
What is your preferred pharmacy (name, location, and / or phone number)?	

PAST SURGICAL HISTORY:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

(FOR STAFF USE ONLY)

HEALTH SUMMARY VERIFICATION:

_____ (DATE) (ANY CHANGES?) (INITIALS)	_____ (DATE) (ANY CHANGES?) (INITIALS)
_____ (DATE) (ANY CHANGES?) (INITIALS)	_____ (DATE) (ANY CHANGES?) (INITIALS)
_____ (DATE) (ANY CHANGES?) (INITIALS)	_____ (DATE) (ANY CHANGES?) (INITIALS)



ADVANCED DERMATOLOGY
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PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED
 (PRINT AND PRESS HARD)

Date Verified: _____ Initials: _____

Patient Number _____ Today's Date _____

PATIENT NAME: (This section refers to PATIENT ONLY)

Name _____
 Last First M.I. Nickname
 Address _____ Apt. # _____
 P.O. Box _____ City _____ State _____ Zip _____
 Home Phone () _____ Work Phone () _____ Cell Phone () _____
 Date of Birth _____ Age _____ Sex _____ Social Security # _____ Employer _____
 Is the Patient? (circle one) Single Married Separated Divorced Widowed Email _____
 Spouse's Name _____ Employer _____ Work Phone () _____

RESPONSIBLE PARTY: (Person responsible for balance not covered by insurance)

Name _____ Relation _____ Date of Birth _____
 Address _____ Employer _____
 P.O. Box _____ City _____ State _____ Zip _____
 Home Phone () _____ Work Phone () _____ Social Security # _____

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name _____ Home Phone () _____
 Address _____ Work Phone () _____

REFERRAL INFORMATION: (Please check the appropriate box below to help us determine how you were referred to our office)

- Physician Friend Relative One of our Patients

 First Name Last Name

- Yellow Pages Referral Service Insurance Other

Which? _____

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance _____	Secondary Insurance _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone: () _____	Phone: () _____
Primary Insured Person _____	Primary Insured Person _____
ID/Policy # _____ Suffix _____	ID/Policy # _____ Suffix _____
Group # _____	Group # _____
Employer _____	Employer _____
Copay \$ _____	Copay \$ _____

I hereby acknowledge that I have received a copy of Advanced Dermatology Skin Cancer & Laser Surgery Center, P.C. Notice of Privacy Practices. I the undersigned give authorization to release any medical information necessary to process this and all future claims and authorize payment of medical benefits for all physician services or supplies to be made to Advanced Dermatology Skin Cancer & Laser Surgery Center, P.C. I agree to be responsible for any self-pay (non-insurance balance), deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

X _____ DATE _____
 Signed (Insured or Authorized Person)