BEACHES
DERMATOLOGY

**The doctors and staff of Beaches Dermatology welcome you as our new patient. In order to give you the best medical care, it is important that we have your medical history for our records. Please answer the following questions:**

# Intake and History Form

Name: _____ Date of Birth: _____ Gender: F M

Street Address: _____

City/State: _____ Zip Code: _____

Phone Numbers (home) _____ (cell) _____ (work) _____

Email Address: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

## Preferred Pharmacy

Name of pharmacy: _____

Location: _____ City/Zip Code: _____

## Occupation and Workplace: _____

How many times in the past year have you had 5 or more drinks in a day (men), 4 or more drinks in a day (women) and any adult older than 65? _____

**Smoking Status:**

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never smoker

**Driving Status:**

- ☐ Drives in the daytime
- ☐ Drives at night

**Alcohol Intake:**

- ☐ None
- ☐ 1 or less per day
- ☐ 3 or more per day

**Caffeine Use:**

- ☐ Once a day
- ☐ Several times a day
- ☐ Few times a week
- ☐ Never

**Pneumonia Vaccine:**

- ☐ Previously received
- ☐ Not received
- ☐ Allergy to vaccine

**Exercise:**

- ☐ Once a day
- ☐ Few times a week
- ☐ Never

**Flu Vaccine:**

- ☐ Previously received
- ☐ Not received
- ☐ Allergy to vaccine

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# Intake and History Form

## Medications:

☐ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

## Allergies:

☐ None

_____ _____

_____ _____

## Skin Disease - Have you had any of the following?

☐ Acne
☐ Actinic Keratoses
☐ Asthma
☐ Basal Cell Carcinoma
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever / Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ NONE
☐ Other:

_____
_____
_____
_____
_____

## Family History - Has any blood relative had any of the following (only include first-degree relatives):

☐ Melanoma _____
☐ Numerous Moles _____
☐ Psoriasis _____
☐ Eczema _____
☐ Severe Acne _____
☐ Polycystic Ovary Disease _____
☐ Diabetes _____
☐ Arthritis _____
☐ Thyroid Disease _____
☐ Chronic Skin Disease _____
☐ Athsma _____
☐ Internal Cancer _____

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# Intake and History Form

## Past Medical History - Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

## Please list previous surgeries and hospitalizations:

_____

_____

_____

_____

_____

_____

_____

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# Financial Policy for Patients

1. Your insurance policy is a contract between you and your Insurance company. As a service to you, we will file your insurance claims for you. It is your responsibility to know the terms of your insurance policy, included but not limited to, Co-insurances, Co-pays, Deductibles, Referrals, Non-covered charges. **If reimbursement from your insurance company is not received within a reasonable period (45 DAYS), we will look to you for payment.** If we later receive a payment from your insurer we will refund any overpayment to you. The patient/guarantor are financially responsible for all charges incurred. Co-pays, co-insurance, deductibles, and any past due charges are due at the time of service.

2. I hereby authorize my insurance carrier to pay benefits directly to Beaches Dermatology. I further acknowledge that any insurance benefits when received, will be credited to my account in accordance with my insurance company's assignment. Any unpaid charges will be the patient/guarantor responsibility. **Payments are due upon receipt of a statement from our office.**

3. I hereby authorize Beaches Dermatology to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition. I authorize Beaches Dermatology to release to appropriate agencies, any information needed to secure payment for any and all services provided.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

# Notice of Privacy Practices - Patient Acknowledgement

I have been provided and understand Beaches Dermatology's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information and my individual rights.

I understand that Beaches Dermatology reserves the right to change the terms of its Notice of Privacy Practices and will provide a revised Notice of Privacy Practices upon my request.

_____ _____

Signature of Patient or Responsible Party if a Minor Date