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: _____

Street: _____

City/State: _____ Zip Code: _____

Social Security Number (SSN): _____

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

Email Address: _____

Would you like to receive emails with our cosmetic specials? ☐ Yes ☐ No

Birth Sex: M F Other _____ Preferred Language: _____ Race: _____

What is your current gender identity?

☐ Male ☐ Female ☐ Additional category (please specify): _____

Occupation/Workplace: _____

Insurance Information

Insurance Carrier: _____ Policy Holder: _____

Insured D.O.B. _____ Insured SSN: _____

Preferred Pharmacy

Pharmacy Name: _____

Location: _____ City/Zip Code: _____

Your response is required by Federal Data Standards to the following questions:

Smoking Status:	☐ Current smoker	☐ Former smoker	☐ Never smoker
Pneumonia Vaccine:	☐ Previously received	☐ Not received	☐ Allergy to vaccine
Flu Vaccine:	☐ Previously received	☐ Not received	☐ Allergy to vaccine
Alcohol Intake:	☐ None	☐ 1 or less per day	☐ 3 or less per day

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)?_____

Do you have a health care proxy in the event you are unable to make your own medical decisions?

If yes, Designee's Name: _____ Designee's Phone Number: _____

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Name: _____

Past Medical History

- ☐ None
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Chronic obstructive lung disease
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ End-Stage renal disease Epilepsy
- ☐ H/O: hypertension
- ☐ Hearing Loss
- ☐ H/O: cerebellar stroke
- ☐ H/O: gastroesophageal reflux disease
- ☐ Hypercholestrerolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignat tumor of prostate
- ☐ Radiation therapy treatment
- ☐ Transplantation of bone marrow
- ☐ Other: _____

Past Surgeries and Hospitalizations

_____

_____

_____

_____

Skin Disease History

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma: Where/When _____
- ☐ Contact dermatitis due to poison ivy
- ☐ Dysplastic Nevus
- ☐ Eczema
- ☐ H/O: asthma
- ☐ Melanoma: Where/When_____
- ☐ Pruritis of scalp
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma: Where/When_____
- ☐ Severe dry skin
- ☐ Other: _____

Do you wear sunscreen? ☐ Yes ☐ No

Do you tan in tanning salons? ☐ Yes ☐ No

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Name: _____

Medications- List all current medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies- List all allergies and reactions if known: ☐ None

_____ _____

_____ _____

Alerts- Have you had any of the following?

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to antibiotic ointments
- ☐ Artificial heart valve
- ☐ Defibrillator
- ☐ HIV
- ☐ Lymphedema
- ☐ Lymph node removal
- ☐ H/O: MRSA
- ☐ Pacemaker
- ☐ Pregnant or planning to become pregnant
- ☐ Require premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Problems bleeding or healing
- ☐ Allergy to latex

Family History- Has any blood relative had any of the following:

Melanoma _____

Numerous Moles _____

Psoriasis _____

Severe Acne _____

Polycystic Ovary Disease _____

Arthritis _____

Diabetes _____

Thyroid Disease _____

Chronic Skin Disease _____

Asthma _____

Internal Cancer _____

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Financial Policy for Patients

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 your 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.

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 patient/guarantor responsibility. Payments are due upon receipt of a statement from our office.

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

_____

Print Name

Notice of Privacy Practices- Patient Acknowledgment

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

Informed Consent for Communication with Patients

I give permission to staff at Beaches Dermatology to leave detailed telephone messages regarding test findings, biopsy results, medication refills, financials, and other matters involving my dermatological care.

We may speak to or leave messages with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Patient OR Responsible party if a minor Date