Patient Information for Certified Dermatology

Name: Sex: Marital Status:

Street Address: City: State: Zip Code:

Home Phone: Business Phone: Cell Phone:

Social Security Number: Date of Birth: Occupation:

Name of Employer/School:

Street Address: City: State: Zip Code:

Referring Doctor's Name: Pharmacy Name:

Referring Doctor's Phone Number: Pharmacy Phone Number:

In Case of Emergency Who Are We Authorized to Contact

Name: Relation: Phone:

Street Address: City: State: Zip Code:

Brief Medical History

1. What is your skin problem (rash, growth, wart)? _____
   _____
2. Where is your skin problem?_____
3. Have you used any treatment for your skin problem? If no write no. If yes please give the names of *everything* used:
   _____
4. How long have you had your skin problem?_____
5. Are you allergic to any medicines? (Penicillin, Sulfur, etc.) If no write no. If yes please list:
   _____
6. Please list all pills, medicines, or tablets you are presently taking:
   _____
   _____
7. Are you currently pregnant? [ ]Yes [ ]No [ ] I am unable to become pregnant
8. It is recommended by the American Academy of Dermatology that you have a complete examination of the skin on your first visit. This requires that you to be appropriately gowned so that we may examine the total skin surface for potentially cancerous growths. Do you wish to have this examination which is included at no additional fee? [ ] Yes [ ] No

MEDICAL HISTORY: Please mark any conditions you may have

[ ] Heart Disease	[ ]Stroke	[ ]Cancer-type:_____	[ ]Eczema
[ ] Heart Valve Replacement	[ ]High Cholesterol	[ ]Diabetes	[ ]Psoriasis
[ ] Heart Failure	[ ]Rheumatoid Arthritis	[ ]Anemia	[ ]Skin cancer
[ ] Pacemaker	[ ]Lupus	[ ]Seizures	[ ]Depression/Anxiety
[ ] Defibrillator	[ ]Artificial Joints-Year_____	[ ]Thyroid Disease	[ ]High Blood Pressure
[ ] Heart Attack	[ ]Hepatitis-type:_____	[ ]HIV/AIDS	[ ]Other-list below:

_____

_____

I request that payment of authorized benefits be made to either me or on my behalf to Certified Dermatology for any services provided. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.

I verify the accuracy of all of the above information including address, phone number, and medical history

Patient's or Authorized Designee's Signature: DATE:

Patient's or Authorized Designee's Signature Renewal: DATE:

Patient's or Authorized Designee's Signature 2nd Renewal: DATE:

Patient's or Authorized Designee's Signature 3rd Renewal: DATE: