Dermatology Center
of Canyon County

Patient Information

PATIENT'S FULL NAME		SOCIAL SECURITY#/DL#	
DATE OF BIRTH / /	❑MALE ❑FEMALE	❑SINGLE ❑MARRIED ❑WIDOWED ❑DIVORCED	
MAILING ADDRESS	CITY	STATE	ZIP
PARENT OR GUARDIAN (IF PT IS A MINOR)			
PRIMARY PHONE	OTHER PHONE		
PATIENT OR GUARDIAN'S EMPLOYER	WORK PHONE		
EMERGENCY CONTACT	RELATIONSHIP	PHONE	
PRIMARY INSURANCE COMPANY ID#	GROUP#	POLICY HOLDER	DATE OF BIRTH
SECONDARY INSURANCE COMPANY ID#	GROUP#	POLICY HOLDER	DATE OF BIRTH

RACE
❑DECLINED TO PROVIDE
❑WHITE
❑HISPANIC
❑ASIAN
❑BLACK OR AFRICAN AMERICAN
❑NATIVE HAWAIIAN /OTHER PACIFIC ISLANDER
❑AMERICAN INDIAN OR ALASKA NATIVE

ETHNICITY
❑DECLINED TO PROVIDE
❑HISPANIC OR LATINO
❑NOT HISPANIC OR LATINO
❑UNKNOWN/OTHER RACE

PREFERRED LANGUAGE
❑ENGLISH
❑SPANISH
❑OTHER_____
❑UNSPECIFIED

PREFERRED CONTACT FOR APPOINTMENT REMINDERS ❑PHONE ❑TEXT

PREFERRED PHARMACY(STORE AND LOCATION)_____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN**_____

May we leave medical information on your answering machine or cell phone? ❑ YES ❑NO

May we e-mail promotional information to you? ❑YES E-MAIL_____ ❑NO

Do you give our office permission to discuss your medical information with family members?

❑YES If yes, whom?_____ ❑NO

ASSIGNMENT OF BENEFITS: I hereby assign all applicable benefits and direct that payment be made directly to the Dermatology Center of Canyon County for all services provided to/for me during my visits.

RELEASE OF INFORMATION: I authorize the Dermatology Center of Canyon County to release medical information to my primary care or referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions.

FINANCIAL RESPONSIBILITY: I understand that **PAYMENT IS DUE AT THE TIME OF SERVICE FOR "MY PART" OF ALL CHARGES** and agree that I am responsible for payment of all charges including those not paid by my insurance in a reasonable time. Small balance credits of less than $1.00 will be written off on my account. Any unpaid balance after 90 days may be sent over to a third party billing or outside collection agency. For minors, the parent or guardian bringing the child in for treatment is the responsible party.

NOTICE OF PRIVACY PRACTICES: As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by the Dermatology Center of Canyon County.

Patient Signature: _____ Date:_____/_____/_____
(For minors, parent or guardian signature)

NAME:_____ **AGE:**_____**DATE OF BIRTH:**_____

Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia(High)
Hyperthyroidism(High)
Hypothyroidism(Low)
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other _____

_____

None

Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast Biopsy (Right, Left, Both)
Lumpectomy (Right, Left, Both)
Mastectomy (Right, Left, Both)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy
Gallbladder Removed
Heart: Biological Value Replacement
Coronary Artery Bypass
Heart Transplant
PTCA
Joint Replacement:
Hip (Right, Left, Both)
Knee(Right, Left, Both)
within last 2 years Y or N
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver: Hepatectomy
Transplant
Shunt
Ovaries: Removed
Endometriosis
Cancer
Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate: Biopsy
Cancer
TURP
Rectum: APR OR Low Ant Resection
Skin: Basal Cell Cancer
Melanoma
Skin Biopsy
Squamous Cell Carcinoma
Spleen Removed
Testicles Removed (Right, Left, Both)
Uterus: Hysterectomy
Fibroids
Uterine Cancer
Cervical Cancer

Other _____

_____

None

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Itchy Skin
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other_____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?

_____

NAME:_____ **DATE OF BIRTH:**_____

Medications (Please enter all current medications)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (Please enter all <u>medication</u> allergies including reaction)

_____ _____ _____

_____ _____ _____

_____ _____ _____

<u>Social History</u>: <u>(please circle one)</u>

<u>Cigarette Smoking:</u>
Never smoked
Quit former smoker
Current smoker
Packs a day_____

<u>Alcohol Use:</u>
YES ❑Less than 1 daily ❑ 1-2 daily ❑ 3 or more daily
NO

<u>Alerts</u>: <u>Are you currently experiencing any of the following</u> <u>(Circle all that apply)</u>

Allergy to adhesive
Allergy to lidocaine
Allery to topical antibiotic ointments
Artificial or damaged heart valve
Artificicial joint within past 2 years
Blood Thinners
Defibrillator
MRSA
Pacemaker
Premedication require prior to procedures
Rapid heartbeat with epinephrine
Pregnancy or planning a pregnancy

Other _____