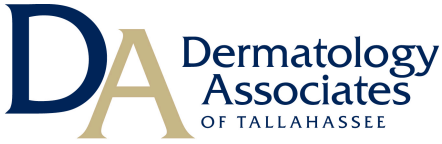


Patient Information Sheet



Account No. _____
Physician _____
Date _____

PLEASE PRINT

Name of Patient _____ Age _____
(Last) (First) (Middle)

Date of Birth _____ SS# _____ Sex _____ Marital Status _____

Mailing Address _____
(Street/PO Box) (Apt #) (City) (State) (Zip)

Best Daytime Contact Phone Number

Evening Phone Number

Alternate Phone Number

Cell Home Work

Cell Home Work

Cell Home Work

Email Address _____

Emergency Contact (not living with you) _____
(Name) (Relationship) (Phone Number)

Primary Care Physician _____
(Name) (City/State)

Occupation/Previous Occupation _____ Retired: Yes No

Patient's Employer _____
(If child, give parents information) (Name) (City/State)

The Federal Government requests that we collect the following information:

Race: American Indian Asian Black White Type-Unknown

Ethnicity: Hispanic Non-Hispanic Type-Unknown **Preferred Language:** _____

It is the policy of this practice to collect payment at time of service.

Primary Insurance (please circle) Policy # _____
FL Blue Cross/Shield PPC/PPO Medicare Coventry Health Care Capital Health Plan United Health Care Other _____

Secondary Insurance (please circle) Policy # _____
FL Blue Cross/Shield PPC/PPO Medicare Coventry Health Care Capital Health Plan United Health Care Other _____

Name of Policy Holder: _____ **Policy Holder Date of Birth:** _____

OVER

MEDICAL HISTORY

Do you have any of the following health problems? **Please check all that apply.**

- | | | |
|---|---|--|
| <input type="checkbox"/> Basal/ Squamous Cell Skin Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint replacement or hardware |
| <input type="checkbox"/> Melanoma Skin Cancer | <input type="checkbox"/> Hepatitis B/C | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> HIV | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Sun Sensitivity | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Dry/Sensitive Skin | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Cancer (Non-Skin Cancer) | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Taking Blood Thinners | <input type="checkbox"/> Heart Attack |

Are you pregnant? Yes No **If yes, notify nurse**

Current smoking status: Smoke every day Smoke sometimes Former smoker Never smoked

ALLERGIES: Are you allergic to any medications? Yes No **If yes, list medication and the reaction you had:**

CURRENT MEDICATIONS: (list all medications and dosage you take on a regular basis or every once in a while):

OTHER MAJOR MEDICAL PROBLEMS/ OPERATIONS/ HOSPITALIZATIONS:

REASON FOR SEEING DOCTOR TODAY: _____

Have you sought care for this problem elsewhere? Yes No If yes, where? _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS FOR PHYSICIANS.

COMMERCIAL INSURANCE

I hereby authorize the release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO DERMATOLOGY ASSOCIATES OF TALLAHASSEE. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature (patient or guardian) _____

MEDICARE INSURANCE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Associates of Tallahassee for any services furnished to me by Dermatology Associates of Tallahassee. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services.

Signature (patient or guardian) _____