SUMMERLIN DERMATOLOGY

PATIENT INFORMATION

Date________

Name: ____

Address: ______________________________________

City, State, Zip________________________________

Phone Number: _________________________________

Sex: M__ F__ Age___ D.O.B.___________

Single_Married_Widowed_Separated_ Divorced_

SS# (**REQUIRED**)_____________________________

If the patient is under the age of 18, please fill the following fields.

Guardian Name (if applicable) __________________

SS# (**REQUIRED**)____________________________

Occupation: ___________________________________

Employer: _____________________________________

Alternate Phone Number: _______________________

INSURANCE INFORMATION

Primary Insurance: ____________________

Group Number: _________________________

Who is responsible for the account?_________

Relationship to patient:___________________

Employer:_______________________________

Employer phone#:________________________

D.O.B.____________SS#__________________

Secondary Insurance: _____________________

Group Number: ____________________________

Who is responsible for the account?___________

Relationship to patient: _____________________

Employer: _______________________________

Employer phone#: ___________________________

D.O.B. _____________SS# __________________

Whom may we thank for referring you? ____

EMERGENCY CONTACT

Name:____

Phone Numbers:__________________________________

Relationship:______________________________

____

Written Acnowledgement of the Receipt of Privacy Practices Notice.

I, (Patient Name)______________________, have received a copy of Summerlin Dermatology's Notice of Privacy Practices.

____

Signature of patient or parent/guardian
(If under 18, parent/guardian signature is required)

____

Date

Office Policies—Please Initial each Line

A **$30.00 fee** will be charged to your account if:

______1. **Your check is returned for insufficient funds.**
______2. **Your account is placed with an outside collection agency.**
______3. **You fail to cancel your appointment with the office or our answering service 24 hours prior to your scheduled appointment.**

MEDICAL INFORMATION

What is the reason for your visit today? ____
____
____

Current Medications:
____
____
____

Allergies:
____
____
____

Medical History:(please check any that apply)

General	**Gastrointestinal**	**Eye,Ear,Nose,Throat**	**Men Only**
_Chills	_Poor Appetite	_Bleeding gums	_Penile Discharge
_Depression	_Bowel changes	_Blurred Vision	_Sore on Penis
_Fever	_Constipation	_Difficulty Swallowing	Other:_________
_Headache	_Diarrhea	_Earache/discharge	
_Loss of weight	_Nausea	_Hoarseness	**Women Only**
_Numbness	_Vomiting	_Nosebleeds	_Hot flashes
_Sweating	_Stomach ache	_Sinus Problems	_Nipple discharge
			_Painful intercourse
Urinary	**Cardiovascular**		_Vaginal discharge
_Blood in the urine	_Chest pain		LMP:__________
_Frequent urination	_Irregular/rapid heart beat		Pregnant: Y or N
_Painful urination	_Poor Circulation		

Past Medical History:(please check any that apply)

_AIDS	_Diabetes	_Kidney disease	_Thyroid problems
_Arthritis	_Glaucoma	_Liver disease	_Tuberculosis
_Asthma	_Heart Disease	_Measles	_Ulcers
_Bleeding disorders	_Hepatitis	_Pacemaker	_Venereal disease
_Cancer	_Herpes	_Rheumatic fever	
_Chemical dependency	_High Cholesterol	_Scarlet fever	
_Chicken pox	_HIV	_Stroke	

Family History:(please check any that apply to any of your blood relatives)

_Asthma	_Hay fever	_Diabetes	_Bleeding disorder
_Eczema	_Malignant Melanoma		

SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any member of his staff responsible in any way for any errors or omissions that I may have made in the completion of the this form.

Signature:_________________________________ Date:___________________________________