

SUMMERLIN DERMATOLOGY

PATIENT INFORMATION

Date _____

Patients Name: _____

Address: _____

City, ST & 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 out Parent or Guardians info in the following fields)

Guardian Name (if Applicable) _____

SS# (REQUIRED) _____

Occupation: _____

Employer: _____

Alternate Phone # : _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Group number: _____

Who is responsible for the account? _____

Relationship to patient: _____

Employer: _____

Employer phone #: _____

D.O.B. _____ SS# _____

SECONDRARY 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 _____ Relationship _____

Phone #'s _____

Written Acknowledgement 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
(IF UNDER 18, PARENT/GUARDIAN SIGNATURE IS REQUIRED)

DATE

A \$25.00 fee will be charged to you 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 you appointment with the office or our answering service 24 hours prior to you scheduled appointment.

OFFICE POLICIES- Please Initial each line

What is the reason for your visit today? _____

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MEDICATIONS- Please list all medications you are taking:

ALLERGIES:

MEDICAL HISTORY:

Please check any and all symptoms you currently have:

General-

- ___ Chills
- ___ Depression
- ___ Fever

Gastrointestinal-

- ___ Poor appetite
- ___ Bowel changes
- ___ Constipation

Eye, Ear, Nose & Throat-

- ___ Bleeding gums
- ___ Blurred vision
- ___ Difficulty Swallowing

Men Only-

- ___ Penile discharge
- ___ Sore on Penis
- Other: _____

MEDICAL INFORMATION

- ___ Headache
- ___ Loss of weight
- ___ Numbness
- ___ Sweat

- ___ Diarrhea
- ___ Nausea
- ___ Vomiting
- ___ Stomach pain

- ___ Ear Ache/discharge
- ___ Hoarseness
- ___ Nosebleeds
- ___ Sinus problems

Women Only-

- ___ Hot flashes
- ___ Nipple discharge

Genito-urinary-

- Blood in the urine
- Frequent urination
- Painful urination

Cardiovascular-

- Chest pain
- Irregular/rapid heart beat
- High/low blood pressure
- Poor circulation

- Painful Intercourse
- Vaginal discharge
- last menstrual period: _____
- Pregnant: Y or N

Please check any and all conditions you currently have or have had in the past:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Scarlet fever | |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke | |

FAMILY HISTORY-

Please check any and all illnesses that have occurred in any of your **blood relatives**: ASTHMA___ HAY FEVER___
 DIABETES___ BLEEDING DISORDERS___ ECZEMA___ MALIGNANT MELANOMA___

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

SIGNATURE _____ DATE _____

SIGNATURES