

**PATIENT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Daytime #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Sex: **M F**

Marital Status: **S M D W**

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**INSURANCE** Primary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Policy #: \_\_\_\_\_

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**Spouse/Parent/Guardian:** \_\_\_\_\_ Social Security #: \_\_\_\_\_

**For Parents Only:** Father's Date of Birth \_\_\_\_\_ Mother's Date of Birth \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Nearest Relative NOT living with you \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

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Referred by: \_\_\_\_\_

**ACCEPTANCE OF FINANCIAL RESPONSIBILITY:** I understand that I am responsible for all medical expenses regardless of insurance coverage. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize REED DERMATOLOGY CLINIC, P.A. to release any information acquired in the course of my examination or treatment to insurance carriers, attorneys or agencies involved in the payment of my account.

**ASSIGNMENT OF BENEFITS:** I hereby authorize payment of medical benefits directly to REED DERMATOLOGY CLINIC, P.A.

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Date

**PARENTS OF MINOR PATIENTS, 18 YEARS AND UNDER** – Please sign and date this authorization.

I hereby authorize REED DERMATOLOGY CLINIC, P.A. to treat my child who is under the age of 18 years. My signature grants permission for any procedures deemed necessary, and any follow up treatments.

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Date

# REED DERMATOLOGY

## Medical Information

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
(First) (Middle) (Last)

Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_

Have **YOU** ever had a skin cancer of any type? No Yes (circle one)  
If yes, was it: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma (circle one)

Where were they located? \_\_\_\_\_

Do **YOU** have a history of other specific skin diseases? No Yes (circle one)

If yes, please list: \_\_\_\_\_

Who is your Family Doctor? \_\_\_\_\_

**ALLERGIC TO:** \_\_\_\_\_ Penicillin \_\_\_\_\_ Sulfa \_\_\_\_\_ No Known Allergies

Other: \_\_\_\_\_

Please explain type of reaction that occurs with these allergies: \_\_\_\_\_  
\_\_\_\_\_

List all medications currently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Do **YOU** have, or have you had any of the following medical problems?

Diabetes	No	Yes	Heart Valve Replacement	No	Yes
High Blood Pressure	No	Yes	Joint Replacement	No	Yes
Glaucoma	No	Yes	Cancer	No	Yes
Heart Disease	No	Yes	HIV/AIDS	No	Yes
Heart Surgery	No	Yes	Tuberculosis/+PPD	No	Yes
Pacemaker	No	Yes	Liver Disease/Hepatitis	No	Yes
Thyroid Disease	No	Yes	Kidney Disease	No	Yes
Asthma/Hayfever	No	Yes	Severe Scarring	No	Yes
Bleeding Disorder	No	Yes	Do You Smoke?	No	Yes
Allergy to Local Anesthetic	No	Yes	Fainting?	No	Yes
Arthritis	No	Yes			

Please list any other significant health problems we should know about: \_\_\_\_\_  
\_\_\_\_\_

Family History: Have any of your immediate family members had skin cancer? No Yes

If yes, who \_\_\_\_\_

### **For Females Of Child-Bearing Age:**

Are you currently pregnant, trying to conceive or breast-feeding? No Yes  
Method of birth control presently using? (please circle one) Birth Control Pills Tubal Ligation  
Hysterectomy Spouse Vasectomy Abstinence Other \_\_\_\_\_

Social History: What is your occupation? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Reviewed and signed by Physician \_\_\_\_\_ Date \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

CHART NUMBER: \_\_\_\_\_

### MEDICAL SERVICE COVERAGE ACKNOWLEDGMENT

I have been informed by Reed Dermatology that the services done today may not be covered by my Health Care Benefits Plan. If this is the case, then I am responsible for payment of services if they are refused by my insurance company.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_