Delmarva Dermatology LLC Patient Information Form

Contact Information

Date	**First Name**
Last Name	**Middle Name or Initial**
Preferred Language	
Gender	
Race ❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Decline to Specify	❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Other Race
Ethnicity ❑ Hispanic or Latino ❑ Unknown	❑ Not Hispanic or Latino ❑ Decline to Specify
Date of Birth:	
Address	
City	**State**
Zip Code	

Additional Contact Information

Home Phone	**Cell Phone**
Work Phone	**E-mail Address**
Best number for reminder calls ❑ Home ❑ Cell ❑ Work	

Emergency Contact Information

Emergency Contact Name	**Emergency Contact Relationship**
Emergency Contact Phone	**Emergency Contact Secondary Phone**

Primary Care Physician / Pharmacy Information

Primary Care Physician	**Office Phone Number**
Office FAX Number	
Preferred Pharmacy Name and Location	
Pharmacy Phone Number	

Medical Insurance Information

Primary Medical Insurance Company	**Group Number**
Member ID or Policy Number	
Policy Start Date	
Policy Holder Name	**Policy Holder DOB**
Policy Holder Relationship to Patient	
Co-Pay Amount	
Referral Required to see Specialist? ❑ Yes	❑ No
Insurance Company Address on Card	
Insurance Company Phone Number on Card	
Additional Information	
Secondary Insurance Company	**Group Number**
Member ID or Policy Number	**Policy Holder Name**
Policyholder DOB	
Additional Information	

Guarantor, Guardian, Responsible Party

If the patient is a minor or under the care of a legal guardian, please fill in this section.	
Legal Guardian Name	
Relationship	**Phone**
Street Address	
City	**State**
Zip	**Country**
I hereby agree to be both financially and legally responable for the services the minor is to receive. I affirm, under penalty of perjury, that I am the legal guardian of the person under my guardianship.	
Guardian Name	
Signature:	
Date:	

Authorization Information

I have read the Notice of Privacy Practices document which contains a Health Insurance Portability and Accountability Act of 1996 (HIPAA) notice on the Delmarva Dermatology, LLC website (DmvDerm.com) By signing below, I verify that I have read the above referenced document and entering my name constitutes a valid electronic signature.
Signature:
Date:
I have read the Office Policies document which contains important information regarding services and payment. This document is provided on the Delmarva Dermatology, LLC website - DmvDerm.com By signing below, I verify that I have read the above referenced document and entering my name constitutes a valid electronic signature.
Signature:
Date:
I hereby authorize Delmarva Dermatology, LLC to release any information necessary for my course of treatment. I also authorize the release of medical information to anyone which Delmarva Dermatology, LLC may release billing or patient care information on a regular basis. In addition, I hereby authorize the release of information to personal acquaintances named below.
Name and Relationship of personal acquaintances to whom you authorize the release of information. **Name** **Relationship** **Name** **Relationship** **Name** **Relationship**
By signing below, I verify the above information is correct to the best of my knowledge and that entering my name constitutes a valid electronic signature.
Signature:
Date:

Authorization Information

We will bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of any co-payments due at the time of service and on receipt of a bill for any deductible and/or co-insurance due as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your health care provider elect to continue treatment past your approved period, you will be responsible for your account balance in full.

I have read and understand the above billing and payment policy.

Signature:

Medical History 1

Patient Name

Date of Birth

Please fill out the following:

Medication Allergies	What Happens?

Please fill out the following:

List of Current Medications (OTC and Prescription)	Reason for Medication

Please fill out the following:

Medical Conditions Known to the Patient:

If you have ever been hospitalized, please list the dates and reason.

Year	Problem / Surgery

Skin Disease History

Have you had any of the following skin conditions? Please check all that apply.

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

Other

Skin Disease History

Does anyone in your family have a history of the following? Please check all that apply:

- ❑ Allergies
- ❑ Asthma
- ❑ Cancer
- ❑ Cancer of the Skin
- ❑ Dermatittis
- ❑ Eczema
- ❑ Psoriasis
- ❑ Melanoma

If you answered Yes for family history of melanoma, please indicate the relationship.

Medical History 2

Please answer Yes or No to the following:

Allergy to Adhesive	❑ Yes ❑ No	**Allergy to Lidocaine**	❑ Yes ❑ No
Allergy to Topical Antibiotic Ointments	❑ Yes ❑ No	**Artificial Heart Valve**	❑ Yes ❑ No
Artificial Joints within the Past 2 Years	❑ Yes ❑ No	**Blood Thinners**	❑ Yes ❑ No
Defibrillator	❑ Yes ❑ No	**MRSA**	❑ Yes ❑ No
Pacemaker	❑ Yes ❑ No	**Premedications Prior to Procedures**	❑ Yes ❑ No
Rapid Heartbeat with Epinephrine	❑ Yes ❑ No	**Pregnancy or Planned Pregnancy**	❑ Yes ❑ No
Problems with Bleeding	❑ Yes ❑ No	**Problems with Healing**	❑ Yes ❑ No
Problems with Scaring (hypertrophic or keloid)	❑ Yes ❑ No	**Rash**	❑ Yes ❑ No
Immunosuppression	❑ Yes ❑ No	**Hay Fever**	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	**Fever or Chills**	❑ Yes ❑ No
Night Sweats	❑ Yes ❑ No	**Unintentional Weight Loss**	❑ Yes ❑ No
Thyroid Problems	❑ Yes ❑ No	**Sore Throat**	❑ Yes ❑ No
Blurry Vision	❑ Yes ❑ No	**Abdominal Pain**	❑ Yes ❑ No
Bloody Stool	❑ Yes ❑ No	**Bloody Urine**	❑ Yes ❑ No
Joint Aches	❑ Yes ❑ No	**Muscle Weakness**	❑ Yes ❑ No
Neck Stiffness	❑ Yes ❑ No	**Headaches**	❑ Yes ❑ No
Seizures	❑ Yes ❑ No	**Cough**	❑ Yes ❑ No
Shortness of Breath	❑ Yes ❑ No	**Wheezing**	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No	**Depression**	❑ Yes ❑ No
Hepatitis C	❑ Yes ❑ No	**Lupus**	❑ Yes ❑ No
Liver Disease	❑ Yes ❑ No	**Herpes**	❑ Yes ❑ No
HIV / AIDS	❑ Yes ❑ No		

Personal Habits

Please answer yes or no to the following:

Do you tan in a tanning salon?	❑ Yes ❑ No	**Do you use sunscreen**	❑ Yes ❑ No

If Yes, what SPF?

Do you smoke or have you smoked in the past?

- ❑ Yes
- ❑ No

Do you have a history of drug use?

- ❑ Yes
- ❑ No