MRN ____________________

Name: ______________________________ **Nick Name:** ______________________ **Date:** ___/___/___

Address: ___________________________________ **City:** _______________ **State:** _______ **Zip:** _______

Gender: ☐ **Female** ☐ **Male** ☐ **Other** **DOB:** ____/____/____ **Birth State:** ______________

Race: _______________ **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Other:** ___________ ☐ **Decline**

Preferred Language ***(Specify)*** ____________________ **Military Service:** ______________ **SS#:** ______________

Home Phone: ____________________ **Cell Phone:** _____________________ **Email:** ____________________
Appt. reminders only

Occupation: ____________________ **Employer:** ____________________ **Marital Status:** ______________

Do we have your permission to leave a voicemail regarding test results? ☐ **Yes** ☐ **No**

Phone Preference: ☐ **Home Phone** ☐ **Cell Phone**

Is there anyone else we can speak with on your behalf? ☐ **Yes** ☐ **No**

Contact: __________________ **Relationship:** ____________________ **Phone:** ___________________

Primary Care Physician: ____________________________ **Phone:** ____________________________

Do you have an advanced healthcare directive or designated decision maker on file with a healthcare provider?

☐ **No** ☐ **Yes, which provider?** ____________________________

ACTIVE CONDITIONS: Are you CURRENTLY receiving treatment for any condition(s) listed below? Check Y or N

	Y	N		Y	N
			Hepatitis: ***Please indicate type:*** ______________	☐	☐
AIDS/HIV	☐	☐	Hypertension	☐	☐
Anxiety	☐	☐	High Cholesterol	☐	☐
Arthritis	☐	☐	Hyperthyroidism	☐	☐
Asthma	☐	☐	Hypothyroidism	☐	☐
Atrial Fibrillation	☐	☐	Leukemia	☐	☐
Bone Marrow Transplantation	☐	☐	Lung Cancer ***(currently receiving treatment)***	☐	☐
BPH (Benign Prostatic Hyperplasia)	☐	☐	Lymphoma	☐	☐
Breast Cancer ***(currently receiving treatment)***	☐	☐	Prostate Cancer ***(currently receiving treatment)***	☐	☐
Colon Cancer ***(currently receiving treatment)***	☐	☐	Radiation Treatment	☐	☐
COPD	☐	☐	Seizures	☐	☐
Coronary Artery Disease	☐	☐	Stroke	☐	☐
Depression	☐	☐	End Stage Renal Disease	☐	☐
Diabetes	☐	☐	**Other medical conditions not listed?**		
GERD	☐	☐			
Hearing Loss	☐	☐			

PAST SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N

	Y	N		Y	N
Appendix (Appendectomy)	☐	☐	Kidney Stone Removal	☐	☐
Bladder (Cystectomy)	☐	☐	Kidney (Nephrectomy)	☐	☐
Mastectomy (Left, Right, Bilateral)	☐	☐	Joint Replacement, Knee (Right, Left, Bilateral)	☐	☐
Lumpectomy (Left, Right, Bilateral)	☐	☐	Joint Replacement, Hip (Right, Left, Bilateral)	☐	☐
Breast Biopsy (Left, Right, Bilateral)	☐	☐	Spleen (Splenectomy)	☐	☐
Breast Reduction	☐	☐	Prostate (Prostatectomy)	☐	☐
Breast Implants	☐	☐	TURP (transurethral resection of the prostate)	☐	☐
Gallbladder (Cholecystectomy)	☐	☐	Skin Biopsy	☐	☐
Coronary Artery Bypass	☐	☐	Hysterectomy	☐	☐
(PTCA) Percutaneous transluminal coronary angioplasty	☐	☐	Heart Valve Replacement	☐	☐

Transplant History (check all that apply)

☐ Heart ☐ Liver ☐ Kidney ☐ Pancreas

Other surgeries not listed?

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SKIN DISEASE HISTORY: Have you ever had any of the following conditions? Check Y or N					
	Y	N		Y	N
Acne	☐	☐	Precancerous Moles	☐	☐
Actinic Keratosis	☐	☐	Psoriasis	☐	☐
Basal Cell Cancer: *Year/Site*________/___________	☐	☐	Squamous Cell Cancer: Year/Site______/________	☐	☐
Blistering Sun Burns	☐	☐	Do you apply sunscreen?	☐	☐
Dry Skin	☐	☐	If yes, what SPF do you use? __________		
Eczema	☐	☐	Do you tan in a tanning salon?	☐	☐
Flaking or Itchy Scalp	☐	☐	Are you pregnant?	☐	☐
Hay Fever/ Allergies	☐	☐	Are you breast feeding?	☐	☐
Poison Ivy	☐	☐	Any family history of Melanoma? (Check all that apply)		
Melanoma: *Year/Site*__________/____________	☐	☐	□ Mother □ Father □ Sister □ Brother □ Son □ Daughter □ Other		

SOCIAL AND VACCINATION HISTORY			
Do you smoke cigarettes? ☐ Yes ☐ No			If you're a former smoker, when did you quit smoking? ____/______ (mm/yy)
Did you have a Pneumonia Vaccination?	☐ Yes	☐ No	**If yes**, when? ____/______ (mm/yy)
Did you receive an Influenza (aka "flu") shot?	☐ Yes	☐ No	**If yes**, when? ____/______ (mm/yy)
Are you allergic to adhesive?	☐ Yes	☐ No	
Are you allergic to Latex?	☐ Yes	☐ No	
How many times in the past year have you had 4 or more alcoholic drinks in a day? ☐ Never ☐ No Alcohol Use ☐ 1-2 Days ☐ 3 or More Days			

PLEASE LIST ANY MEDICATION ALLERGIES		

PLEASE LIST ALL MEDICATIONS		
Medication Name	**Dose/Strength**	**How Often**
Example: Aspirin	***81mg***	***1/day***

Preferred Pharmacy: ______________________________ Phone: ______________________________

Address/ City/Zip: ____

Primary Insurance Carrier:________________________ Name of Insured (Subscriber): ____________________

Subscriber DOB: ___/___/____ Subscriber Gender: ☐ Male ☐ Female Relationship to patient: ________________

PAYMENT OF BENEFITS/ AUTHORIZATION OF TREATMENT

I hereby authorize treatment from any licensed medical professional within Parks Dermatology Center, LLC. I understand that this authorization may be used now or in the future. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. We accept VISA, MasterCard, AMEX, DISCOVER and Care Credit for your convenience. Your signature below indicates that you understand and accept this policy. I request the direct payment of all authorized medical benefits to be made to Parks Dermatology Center for any services I received by the physicians or laboratory of Parks Dermatology Center. I authorize any holder of medical information about me to release this information to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred. Parks Dermatology Center, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature:____ Date: ____/____/_____