



Annual Patient History Form

MRN: _____

Name: _____ D.O.B.: ____/____/____ Date: ____/____/____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

Marital Status: _____ Social Security #: _____

Do we have your permission to leave a message regarding test results? Yes No

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

Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician (PCP): _____ Phone: _____

Do you have an advanced healthcare directive or designated decision maker on file with a healthcare provider? No Yes, which provider? _____

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

Any new medical conditions diagnosed in the last 12 months? (i.e., Diabetes, Hypertension, Heart Conditions, Cancer)

- None Yes (please specify) _____

Have you had a Pneumonia shot?

- No Yes (mm/yyyy): ____/____

Did you receive an Influenza shot (a.k.a. "flu")?

- No Yes (mm/yyyy): ____/____

Current Insurance:

Primary Insurance Carrier: _____ Name of Insured (Subscriber): _____

Subscriber DOB: ____/____/____ Subscriber Gender: M F 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: ____/____/____