Buckeye Dermatology, Inc

Welcome to our office. Please take a moment to complete this form. Please present insurance card(s) and photo ID to the receptionist so copies can be made. ***Thank you.***

PATIENT INFORMATION: (Please Print) Date_____/_____/_____

SS#_____ Marital Status: M S W D

Name _____
(First) (M.I.) (Last)

Mailing Address _____
Number and Street City Ohio Zip

Sex _____ Age _____ Date of Birth _____/_____/_____

Home (_____)_____ Cell (_____)_____ Work (_____) _____

Please address all Billing Statements to:_____

PRIMARY INSURANCE

Insurance Company _____
Name of Insured_____
Date of Birth _____/_____/_____
SS#_____
Insured ID _____
Group # _____
Co-payments $ _____
Employer Name_____
Employer Address _____
Employer Phone (_____)_____
Relationship to Patient _____

SECONDARY INSURANCE

Insurance Company _____
Name of Insured_____
Date of Birth _____/_____/_____
SS# _____
Insured ID#_____
Group # _____
Co-payment $ _____
Employer Name _____
Employer Address _____
Employer Phone (_____) _____
Relationship to Patient_____

★ ***Can we call you with results or to answer your questions at your:*** (please list all that apply)
Cell Phone Number (____) _____ EMAIL ADDRESS
Home Phone Number (____) _____ _____
Work Phone Number (____) _____

Pharmacy of choice _____ Phone (____) _____
In case of emergency, who should be notified? _____ Phone (____) _____
Name & Address of Referring Physician (if known) _____
Primary Care Physician _____

I authorize the release of medical information to my primary care or referring physician, to consult if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician/Buckeye Dermatology. **I understand that I am financially responsible for the services rendered, regardless of insurance coverage. If my insurance company requires referrals or prior authorization, it is my responsibility to obtain them prior to each service. If this is not obtained, I will be responsible for payment of my medical bill. Finally, I agree to pay for a "no show" fee of $25 (office visit), $50 (surgery) in the event of missing my scheduled appointment and not cancelling prior to 24 hours before my appointment. In the event that your account must be turned over to collections, a $30.00 collection fee will be added to your account's outstanding balance. There will be a $30.00 fee on returned checks. Your signature below signifies your understanding and willingness to comply with these policies.**

Patient or Responsible Party **X** _____ Date _____/_____/_____
SIGNATURE

MEDICAL HISTORY FORM

In regard to your single most important skin problem, please answer the following questions:
(*The dermatologist may not be able to address all of your skin problems during your initial visit*.)

Please briefly describe your skin problem:_____
List parts of your body affected:_____
How long have you had the problem:_____
List symptoms and how bad they are (itch,burn,sting,hurt,other,etc.) _____
List treatments and whether they helped: _____
Current Medications:_____
Drug Allergies: _____

Are you pregnant or planning a pregnancy or currently nursing? ☐Yes ☐No
Explain:_____
If pregnant, how many weeks _____ Any medical complications?_____
Do you take aspirin on a regular basis? ☐Yes ☐No
Occupation:_____

FAMILY HISTORY

☐ Psoriasis	☐ Hay Fever	☐ Cancer	☐ Skin Diseases
☐ Skin Cancer	☐ Asthma	☐ Hair Loss	☐ Depression
☐ Eczema	☐ Diabetes	☐ Arthritis	☐ Other:_____

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

- ☐ Psoriasis
- ☐ Keloid/Bad Scarring
- ☐ Skin Cancer
- ☐ Eczema
- ☐ Hair Loss ☐Progressive ☐ Recent
- ☐ Dry Skin
- ☐ Itchy Skin
- ☐ Oily Facial Skin
- ☐ Acne
- ☐ Cold Sores/Herpes
- ☐ Dandruff
- ☐ Heart Problems
- ☐ Leg Swelling
- ☐ Varicose Veins
- ☐ Pacemaker
- ☐ Heart Valve Problems
- ☐ High Blood Pressure
- ☐ Lung Problems(Including TB Exposure)
- ☐ Gastrointestinal Problems
- ☐ Eye Problems/Glaucoma/Cataracts
- ☐ Hepatitis/Liver Problems/Jaundice
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Headaches ☐ Migraines
- ☐ Seizures/Neurologic Problems
- ☐ Depression/Psychiatric Issues
- ☐ Anemia
- ☐ Bleeding Easily or Blood Clots
- ☐ Internal Cancer. Type?_____
- ☐ Previous Surgery:_____
  _____
- ☐ Recent Fever
- ☐ X-Ray or Radiation Exposure
- ☐ Recent Weight Loss or Gain
- ☐ Recent Weakness/Tiredness
- ☐ Recent Cold or Flu
- ☐ Recent Sore Throat
- ☐ Recent Hospitalization

  Reason_____
  _____
- ☐ Frequent Sunburns
- ☐ Sun Sensitivity
- ☐ Venereal Disease
- ☐ Lupus
- ☐ Joint Pain
- ☐ Diabetes/High Blood Sugar
- ☐ HIV+
- ☐ AIDS Risk(Blood Transfusions, Multiple Partners, Unprotected Sex, IV Drug Use)
- ☐ Easy Fainting
- ☐ Joint or Heart Valve Replacement
- ☐ Other_____

Females

- ☐ Irregular Menses
- ☐ Present Birth control use
- ☐ Postmenopausal
- ☐ Increased Facial/Body Hair

For all patients:

Non skin related problems should be brought to the attention of your primary care doctor. If you do not have a primary care doctor, please ask us and we will refer you to one.

HABITS	
	Count
Cigarettes/day	
Alcohol Oz./week	
Tanning/week	
Coffee/Tea Cup/day	
Regular Exercise/week	
Sunscreen use	

Do we have your permission to:
Send benign biopsy results by mail? ☐Yes ☐No
Discuss your medical condition with a member of your household? ☐Yes ☐No
If yes whom: _____Relationship_____

Patient Signature_____Date _____