Medical Intake Form

PRECISION SKIN INSTITUTE

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	DATE / /
STREET ADDRESS	APT #		HOME PHONE ( )
CITY	STATE	ZIP	MOBILE PHONE ( )
DRIVER'S LICENSE # (optional)			SS# (optional) - -
D.O.B. / /	GENDER ☐ MALE ☐ FEMALE	EMAIL	
MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED		PREFERED LANGUAGE (IF OTHER THAN ENGLISH)	
MINOR/UNDER 18 YEARS OLD ☐ YES ☐ NO	GUARDIAN NAME		GUARDIAN PHONE ( )
EMPLOYER		OCCUPATION	
EMPLOYER ADDRESS	CITY STATE ZIP		EMPLOYER PHONE ( )
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT		PHONE ( )
PRIMARY CARE PHYSICIAN			PHONE ( )

HOW DID YOU HEAR ABOUT US?

☐ OUR WEBSITE (PRECISIONSKININSTITUTE.COM ☐ INSURANCE WEBSITE OR LIST ☐ MAGAZINE ☐ FACEBOOK

☐ ANOTHER PATIENT ☐ REFERED BY DOCTOR ☐ OTHER

_____ _____ _____

PERSON RESPONSIBLE FOR PAYMENT

LAST NAME OF PERSON RESPONSIBLE FOR BILL	FIRST NAME	M.I.	HOME PHONE ( )
STREET ADDRESS	APT #		MOBILE PHONE ( )
CITY	STATE	ZIP	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY #	GROUP #
PRIMARY INSURANCE POLICY HOLDER	RELATIONSHIP TO PATIENT	D.O.B. / /
SECONDARY INSURANCE	POLICY #	GROUP #
SECONDARY INSURANCE POLICY HOLDER	RELATIONSHIP TO PATIENT	D.O.B. / /

CONSENTS

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payments of medical benefits to Precision Skin Institute.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Payment is required for all services at the time they are rendered (this includes co-payments, deductibles, co-insurance, deposits, and payments for cosmetic services). I have had a chance to read over the Financial Responsibility Form.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

I have had a chance to read over the HIPAA/Privacy Policy Form.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Medical History Form

PRECISION SKIN INSTITUTE

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	DATE
			/ /

PAST MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY

- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ARTRIAL FIBRILLATION
- ☐ BREAST CANCER
- ☐ COLON CANCER
- ☐ COPD
- ☐ CORONARY ARTERY DISEASE
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ RENAL DISEASE
- ☐ GERD (reflux)
- ☐ HEARING LOSS
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ HIGH CHOLESTEROL
- ☐ LEUKEMIA
- ☐ LUNG CANCER
- ☐ LYMPHOMA
- ☐ PROSTATE CANCER
- ☐ RADIATION TREATMENT
- ☐ SEIZURES
- ☐ STROKE
- ☐ HYPOYTHYROID/HYPERTHYROID
- ☐ OTHER _____

PAST SURGINCAL HISTORY INCLUDING SKIN SURGERY (description/date)

_____ _____ _____

SKIN DISEASE HISTORY

PLEASE CHECK ALL THAT APPLY

- ☐ ACNE
- ☐ ACTINIC KERATOSES
- ☐ ASTHMA
- ☐ BASAL CELL CARCINOMA
- ☐ BLISTERING SUNBURNS
- ☐ DRY SKIN
- ☐ ECZEMA
- ☐ FLAKING / ITCHY SCALP
- ☐ HAY FEVER / ALLERGIES
- ☐ MELANOMA
- ☐ POISON IVY
- ☐ PRECANCEROUS MOLES
- ☐ PSORIASIS
- ☐ SQUAMOUS CELL CARCINOMA
- ☐ OTHER _____

SUN DAMAGE AND SUNSCREEN INFORMATION

DO YOU WEAR SUNSCREEN?	TAN IN A TANNING SALON?	DO YOU SPEND LONG HOURS IN THE SUN?	
☐ YES, (SPF _____) ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	

MEDICATIONS

MEDICATIONS

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES TO MEDICATIONS

_____ _____ _____

SOCIAL HISTORY

PLEASE CHECK ALL THAT APPLY AND PROVIDE APPLICABLE INFORMATION

☐ CIGARETTE SMOKING
- ☐ CURRENTLY DAILY SMOKER
- ☐ SOME DAY SMOKER
- ☐ NEVER SMOKED
- ☐ FORMER SMOKER

OPTIONAL
- ☐ NOT SEXUALLY ACTIVE
- ☐ SEXUALLY ACTIVE
  - ☐ 1 PARTNER
  - ☐ MORE THAN 1 PARTNER
  - ☐ SAME SEX PARTNER

- ☐ DRUG USE
- ☐ IV DRUG USE

☐ ALCOHOL USE
- ☐ NONE
- ☐ LESS THAN 1 DRINK
- ☐ 1-2 DRINKS DAILY
- ☐ 3 OR MORE DRINKS DAILY

FAMILY HISTORY OF SKIN DISORDERS AND/OR SKIN CANCER (1st degree relatives only)

PHARMACY INFORMATION

PHARMACY NAME	LOCATION	PHONE
		( )

ALERTS

PLEASE CHECK ALL THAT APPLY AND PROVIDE APPLICABLE INFORMATION

ALLERGY TO
- ☐ ADHESIVE (BANDAID)
- ☐ LIDOCAINE (NUMBING AGENT)
- ☐ TOPICAL ANTIBIOTICS

CURRENT CONDITIONS
- ☐ ARTIFICIAL HEART VALVE/JOINT
- ☐ DEFIBRILLATOR
- ☐ PACEMAKER
- ☐ HISTORY OF MRSA
- ☐ PREGNANT
- ☐ NURSING
- ☐ REQUIRE ANTIBIOTICS PRIOR TO SURGERY
- ☐ RAPID HEARTBEAT WITH EPINEPHRINE

COSMETIC HISTORY

HAVE YOU EVER HAD A COSMETIC PROCEDURE?

☐ YES, (ANY SIDE-EFFECTS? _____)

☐ NO

ARE YOU INTERESTED IN A COSMETIC PROCEDURE?

☐ YES, (PLEASE SPECIFY _____)

☐ NO