Dermatology Medical History

Patient: ______________________ Date of Birth: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: ______________________

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:
1. ____________ 2. ____________ 3. ____________

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. ________ 3. ________ 5. ________ 7. ________
2. ________ 4. ________ 6. ________ 8. ________

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other disease or conditions: ______________________

List surgical procedures you have had in the last 12 months: ______________________

Skin: Have you ever had skin cancer? ☐ YES ☐ NO If yes, what type ____________
Has anyone in your family had skin cancer? ☐ YES ☐ NO If yes, what type ____________
Do you have a history of any specific skin diseases? ☐ YES ☐ NO If yes, ____________
Do you have problems with healing ☐ YES ☐ NO
Do you develop keloids (scars) after surgery ☐ YES ☐ NO
Do you bleed easily? ☐ YES ☐ NO
Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin
☐ Other ______________________

Social History:
Do you drink alcohol? ☐ YES ☐ NO If YES ________ drinks per day
Do you use IV drugs? ☐ YES ☐ NO If YES, what? ____________ How often? ________
Do you smoke? ☐ YES ☐ NO If YES, how much: ____________
Have you had or have you been exposed to HIV (AIDS) ? ☐ YES ☐ NO

Please answer the following questions:
(Women) Are you pregnant? ☐ YES ☐ NO Due Date: ___/___/___
What is your occupation? ____________ Hobbies? ____________

Completed by: ☐ Patient Patient Signature: ______________________ Date: ________
☐ Medical Assistant

Physician Signature of Review: ______________________ Date: ________

DERMATOLOGY ASSOCIATES OF BIRMINGHAM, P.C.

Today's Date:______________________

Patient Name: First ____________________ MI ________ Last ______________________________

☐ Male ☐ Female Birth date _____ / _____ / _____ Social Security # _____ / _____ / _______

☐ Child ☐ Single ☐ Married ☐ Widowed

Responsible Party Name: ____

Address: ____

____

Phone: Home ______________________ Cell __________________ Work______________________

Employed by:____

Are you a full-time college student? ☐ Yes ☐ No

Other family members who are patients? ____

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Pharmacy of choice:____ Phone #:__________________

In case of emergency, notify:____

Relationship:__________________________ Phone #:_____________________

Referred by:____

Primary Care Physician:____

Do we have permission to:

Leave a message on your answering machine at home? ☐ Yes ☐ No

Leave a message at your place of employment? ☐ Yes ☐ No

Discuss your medical information with a family member? ☐ Yes ☐ No

If yes, whom? _______________________ Relationship: ____________ Date of Birth:_________________

_______________________ Relationship:____________ Date of Birth:_________________

Signature: **X** ____

Patient or Legal Guardian

DERMATOLOGY ASSOCIATES OF BIRMINGHAM, P.C.

INSURANCE INFORMATION - Please present insurance cards and photo ID to receptionist so copies can be made

PRIMARY	SECONDARY
Insurance Name: ______________________	Insurance Name: ______________________
Name of Policy Holder: ______________________	Name of Policy Holder: ______________________
Policy Holder's Birth Date: ______________________	Policy Holder's Birth Date: ______________________
Policy Holder's Social Sec. # ______________________	Policy Holder's Social Sec. # ______________________
Patient's Relationship to Policy Holder: ______________	Patient's Relationship to Policy Holder: ______________

PAYMENT POLICY: Payment is required for all services at the time they are rendered unless you have coverage with an insurance plan in which we participate. For those patients, applicable co-payments and/or deductibles will be collected at the time of service. We accept payment in the form of cash, check, or credit card. There is a $30.00 fee for returned checks. Patient balances that have not been paid after 90 days will be subject to being turned over to a collection agency in which the patient / responsible party will be responsible for all fees incurred.

ASSIGNMENT AND RELEASE: I authorize the release of my medical information to my primary care or referring physician, insurance company and/or consultants if needed and as necessary to process Medicare and Medigap claims, Insurance claims and/or Insurance applications and prescriptions. It is further understood that I request payment of all Insurance benefits including Medicare and if applicable, Medigap benefits to be made on my behalf to Dr. Jeffrey N. Martin, Dermatology Associates of Birmingham, P.C., for any services provided to me by that provider. I understand that I am financially responsible for all charges whether or not paid by Insurance or Medicare. I authorize the use of my signature on all insurance submissions, including Medicare and Medigap.

My signature below signifies that the Insurance information I have given is correct and signifies that I have read and understand the above policies and signifies my willingness to comply with these policies.

My signature below also indicates that I have received a copy of "Notice of Privacy Practices" for Dermatology Associates of Birmingham , P.C.

Signature: X____

Date:______________________