

Eastside Dermatology – Patient Information

PLEASE PRINT & COMPLETE ALL SECTIONS/SIDES OF THIS FORM

Patient Name _____ Date of Birth: _____

(First) (Middle Initial) (Last) Sex M F

Street Address _____

City _____ State _____ Zip _____

Best Contact Phone Number #1: () _____ Cell/Home/Other

Best Contact Phone Number #2 () _____ Cell/Home/Other

SSN# _____ - _____ - _____

If minor, Parent/Legal Guardian _____ Daytime Phone _____

Family Doctor _____ Phone _____

Referral From: Dr. _____ Ad _____ Phone Book _____ Other _____

Insurance Information **Copies of all insurance cards must be provided for claims purposes**

Primary Insurance Company: _____

Secondary Insurance Company: _____

Policy Holder Name: _____

Policy Holder Name: _____

Insured ID#: _____

Insured ID#: _____

Policy Holder SSN: _____ - _____ - _____

Policy Holder SSN: _____ - _____ - _____

Policy Holder DOB: _____ - _____ - _____

Policy Holder DOB: _____ - _____ - _____

Parent or Responsible Party (if different from patient): (person responsible for bills may or may not be policyholder for the insurance)

Name: _____ Relationship: _____

(First) (Middle Initial) (Last) Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Daytime: _____ Cell: _____

Emergency Contact Information:

Name _____ Relationship _____ Phone _____

May we contact you via email if necessary? Y or N If yes, email address _____

May we leave medical information / test results on your voicemail at home? Y or N

May we discuss medical information / test results with your family members? Y or N

If yes, name _____ Relationship _____ Phone _____

I hereby authorize release of information necessary to file a claim with my insurance company. I understand I am financially responsible for any balance not covered by my insurance carrier, and collection/legal fees incurred for Signature unpaid balances.

Signature _____ Date _____

Medicare Patients Only:

I request that payment of authorized medical benefits be made either to me on my behalf or to Eastside Dermatology Inc. for any services provided to me by their physicians. I authorize any holder of information about me to release to the Health Care Financing Administration and it's agents, any information needed to determine benefits payable to related services.

Patient/Guardian Signature _____ Date _____

Please complete other side of form

Patient Health History: In order to treat you safely & effectively, please answer the following questions completely.
This is for our records only; responses are confidential

What problem (s) brings you in today? _____

Medications: (please include both prescription & non-prescriptions) **Write "no" if none**

Are you allergic to any medications? Yes ___ No ___ Please specify _____

Are you allergic to latex? Yes ___ No ___ Pharmacy Name/Telephone # _____

Do you have any of the following? Please circle any that apply to you

- | | | | |
|-----------------------|------------------------|------------------------------------|-------------------------|
| Allergic Symptoms | Bowel Problems | Psychiatric/Emotional Difficulties | Recurrent Mouth Sores |
| Skin-Related Symptoms | Joint Pain | Breathing/Respiratory Symptoms | Seizures |
| Heart/Chest Problems | Pacemaker | Ear, Nose, Mouth, Throat Symptoms | Keloids/Overgrown Scars |
| Kidney Problems | Eye or Vision Problems | Fever, Headache, Nausea, Dizziness | Leg Swelling |
| Stomach Problems | HIV/AIDS | Neurological Symptoms/Problems | Bandaging Tape Allergy |
| Recent Illness | Cold Sores | Elevated BP/Hypertension | Arthritis/Asthma |
| Blood Transfusions | Cough | Unexplained Weight Change | Glaucoma |

Past Medical History / Family History:

Disease	Yourself	Blood Relative	Disease	Yourself	Blood Relative
Eczema	_____	_____	Depression	_____	_____
Diabetes	_____	_____	Psoriasis	_____	_____
Thyroid	_____	_____	Abnormal moles (Dysplastic)	_____	_____

Basal Cell Skin Cancer _____ Location: _____ Year: _____

Squamous Cell Skin Cancer _____ Location: _____ Year: _____

Malignant Melanoma _____ Location: _____ Year: _____

Do you have an artificial heart valve, joint or other prosthesis that requires you to take antibiotics when you have dental work? Yes ___ No ___ If yes, what for? _____

Past Surgery (s) – Do not include routine childbirth, please:

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke? Yes ___ No ___ # packs per day? _____ **Do you drink alcohol?** Yes ___ No ___ How often? _____

For Women Only: Are you: Pregnant? Yes ___ No ___ Trying to become pregnant? Yes ___ No ___
 Breast Feeding? Yes ___ No ___ Taking birth control pills? Yes ___ No ___