Eastside Dermatology – Patient Information
PLEASE PRINT & COMPLETE ALL SECTIONS/SIDES OF THIS FORM

Patient Name_______________ (First) _______________ (Middle Initial) _______________ (Last) Date of Birth: ____/____/____

Street Address_______________________________ **Sex:** ☐Male ☐ Female

City_____________________ State__________ Zip_______________

Best Contact Phone Number #1: ( ) ____________________ ☐Cell ☐Home ☐Other ____________

Best Contact Phone Number #2 ( ) ____________________ ☐Cell ☐Home ☐Other ____________

SSN#_____-_____-_____ **Race:** __________ **Language:** ☐English ☐Spanish ☐German ☐Other__________

If minor, Parent/Legal Guardian____________________ Daytime Phone ( ) ____________

Email Address: ____________________@____________________

Family Dr.____________________ Phone ( ) ____________

Referral From: Dr. ____________________ **or** ☐ Ad ☐ Insurance ☐Phone Book ☐Event ☐ Web Search ☐Other

Insurance Information

Copies of all insurance cards must be provided for claims purposes

Primary: Insurance Company: ____________________

Policy Holder Name: ____________________

Relationship to Patient: ☐Self ☐Spouse ☐Parent

Policy Holder SSN: _____-_____-_____

Policy Holder DOB: _____-_____-_____

Secondary: Insurance Company: ____________________

Policy Holder Name: ____________________

Relationship to Patient: ☐Self ☐Spouse ☐Parent

Policy Holder SSN: _____-_____-_____

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: _______________ (First) _______________ (Middle Initial) _______________ (Last) Relationship: ____________

Address: ____________________ City:______________ State:________ Zip: ________

Best Contact Phone Number #1 :(______) ____________ Best Contact Phone Number #2: :(______)____________

Emergency Contact Information:

Name: ____________________ Relationship:____________________ Phone:(______)____________

May we leave medical information / test results on your voicemail? ☐ Yes ☐ No

May we discuss medical information / test results with your family members? ☐ Yes ☐ No

Patient/Guardian 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 its 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) ☐Yes ☐No ☐See Attached if list given to receptionist

______ ______ ______ ______ ______

______ ______ ______ ______ ______

Have you had the flu vaccine? ☐ Yes ☐ No If yes, approximately when: ______________
Have you had the pneumonia vaccine? ☐ Yes ☐ No If yes, approximately when: ______________

Pharmacy Name: ______________ **Telephone #: (____)** ______________
Do you have a medical or financial durable Power of Attorney? ☐Yes ☐No **Please provide copy of POA**
Are you allergic to latex? ☐ Yes ☐ No
Are you allergic to any medications? ☐ Yes ☐ No **If Yes,** Please specify: ______________

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

Allergic Symptoms	Blood Transfusions	Cold Sores	Recent Mouth Sores
Skin Related Symptoms	Bowel Problems	HIV/AIDS	Seizures
Fever, Headache, Nausea, Dizziness	Breast Feeding	Muscle Pain	Morning Joint Stiffness
Recent Illness	Breathing /Respiratory Difficulties	Joint Pain	Stomach Problems
Ear, Nose, Mouth, Throat Symptoms	Heart/Chest Problems	Keloids/Overgrown Scars	Unexplained Weight Change
Arthritis	Cough	Leg Swelling	Weakness
Asthma	High Blood Pressure/Hypertension	Neurological Symptoms	Diabetes
Back Pain/Injury	Eye or Vision Problems	Pacemaker/Defibrillator	
Bandage Tape Allergy	Glaucoma	Psychiatric/Emotional Difficulties	

Any Other Medical Conditions: ______________________________

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Past Medical History / Family History:

Disease	Yourself	Blood Relative	Disease	Yourself	Blood Relative
Eczema	☐	☐	Depression	☐	☐
Diabetes	☐	☐	Psoriasis	☐	☐
Thyroid	☐	☐	Abnormal moles (Dysplastic)	☐	☐
			Cancer	☐	☐
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 antiobiotics when you have dental work? ☐ Yes ☐ No If yes, what for? ______________

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

Date	Reason	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