DERMATOLOGY CENTER of MCKINNEY

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Please present your insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.

PATIENT INFORMATION

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change **Date:**

Patient's Last Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.	First:	Middle:	Date of Birth	Sex: ☐ Male ☐ Female

Address:	City:	State:	ZIP Code:

Race: ☐ American Indian ☐ Native Hawaiian ☐ Black/African American ☐ Asian ☐ White ☐ Hispanic ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic/Latino Language: ☐ English ☐ Spanish ☐ Indian ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home #:	Work #:	Cell #:

PARENT, SPOUSE, or RESPONSIBLE PARTY *(if different from patient)*

Last Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.	First:	Middle:	Date of Birth	Sex: ☐ Male ☐ Female

Address:	City:	State:	ZIP Code:

Home #:	Work #:	Cell #:

INSURANCE COVERAGE—*PRIMARY*

Insurance Company Name:	Policy Type: ☐ HMO ☐ PPO ☐ HSA ☐ Other _____
Policy #:	Group Name or #:

Address of Claim Center:	City:	State:	ZIP Code:

Customer Service #:	Providers # (if different):	Fax #:

Name of Policy Holder (Insured):	

Relationship to Insured: ☐ Mother ☐ Father ☐ Other _____

Please check one: I have paid my insurance deductible for the calendar year _____ ☐ YES ☐ NO ☐ Don't know

INSURANCE COVERAGE—*SECONDARY*

Insurance Company Name:	Policy Type: ☐ HMO ☐ PPO ☐ HSA ☐ Other _____
Policy #:	Group Name or #:

Address of Claim Center:	City:	State:	ZIP Code:

Customer Service #:	Providers # (if different):	Fax #:

Name of Policy Holder (Insured):	Policy Holder (Insured) Date of Birth:

Relationship to Insured: ☐ Mother ☐ Father ☐ Other _____

PATIENT MEDICAL HISTORY

Patient's Last Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.	First:	Middle:	Date of Birth	SS#:

Primary Care Physician or Pediatrician:	PCP telephone & fax number:

How did you hear about us?

Preferred Pharmacy:

Pharmacy location (city & address or cross street):

EMERGENCY CONTACT INFORMATION

Emergency Contact's Name (First, Last): Relationship to Patient:

Home #: Work #: Cell #:

Do you give our office permission to discuss your medical information with family members?

☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

May we leave personal medical information on your answering machine or cell phone? ☐ YES ☐ NO

May we e-mail personal medical information to you (This will register you on our secure patient portal)? ☐ YES ☐ NO

Would you like to get a text and/or email reminder of future appointments? ☐ Text reminder ☐ Email Reminder ☐ None

E-mail address: _____ Text phone number _____

Would you like to receive our free newsletter by email? ☐ YES ☐ NO (Please note, your email address will ONLY be used for the purpose of receiving our newsletter and will not be sold or made available for use by any other organization. You always have the option of unsubscribing from the mailing list with every newsletter you receive.)

MEDICAL QUESTIONAIRE

In order to help you physician better assess your medical problem and make appropriate treatment recommendations, we ask that you fill out this medical questionnaire. This is an important part of your medical evaluation and your physician will use this form as a guide for a more detailed medical history.

Briefly state what symptoms you are experiencing :

Location(s):

Severity (Itch? Burn? Bleed? Painful?):

How long have you experienced these symptoms?

What have you tried? Did it help?:

Present Medications (include over-the-counter & herbal supplements/vitamins) If needed, use back of page

Name	Dose	How Often
1.		
2.		
3.		
4.		

☐ Check box if additional medications on are back of page

Have you had melanoma skin cancer before? ☐ Yes ☐ No:

If yes: location on body?:

when was it treated?:

how was it treated?:

Have you had any other skin cancer before? ☐ Yes ☐ No:

If yes: what type?:

location on body?:

when was it treated?:

how was it treated?:

Patient/Responsible Party Signature: _____ Date: _____

Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No		Yes	No
Renal Disease	☐	☐	Wheezing	☐	☐	Stomach Absorption Disorder	☐	☐
Hepatitis	☐	☐	Heart Attack	☐	☐	Nausea, Vomiting, Diarrhea	☐	☐
Liver disease	☐	☐	Heart Murmur	☐	☐	when taking antibiotics		
HIV	☐	☐	Stroke	☐	☐	Frequent Bladder Infections	☐	☐
Eczema	☐	☐	Chest Pain	☐	☐	Yeast infections on antibiotics	☐	☐
Psoriasis	☐	☐	Irregular Heartbeat	☐	☐	Fainting	☐	☐
Bronchitis	☐	☐	High blood pressure	☐	☐	Convulsions or Seizures	☐	☐
Emphysema	☐	☐	Diabetes	☐	☐	Arthritis/Joint Deformity	☐	☐
Asthma	☐	☐	Excessive thirst/hunger	☐	☐	Limited Joint Motion	☐	☐
Chronic Cough	☐	☐	Thyroid Problems	☐	☐	Blood Clots	☐	☐
Shortness of Breath	☐	☐	Kidney Problems	☐	☐	Inflammation of Veins	☐	☐
			Arthritis/Joint Deformity	☐	☐			

Do you have any of these conditions:?

- ☐ bleeds excessively
- ☐ tendency to form thick scars or keloids
- ☐ mitral valve prolapse
- ☐ irritation or allergic reaction to bandages
- ☐ irritation or allergic reaction to antibiotic ointments
- ☐ enlarged lymph nodes
- ☐ immunosuppression
- ☐ prosthetic joint(s)
- ☐ pacemaker/defibrillator
- ☐ photosensitivity
- ☐ recent weight change
- ☐ difficult healing

Drug Allergies:

Food Allergies:

Other Allergies:

Has anyone in your family had skin cancer before? ☐Yes ☐No: If yes, who and what type of skin cancer?:

Do any of the following conditions run in your family? Psoriasis: ☐ Eczema ☐ Hair/Nail Problems☐

Are you: A Non-Smoker ☐ Former Smoker, but not currently ☐ Current Smoker ☐ How many /day?:

Do you use tobacco products other than cigarettes? ☐Yes ☐No:

Women only: Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No

Is your menstrual cycle regular? ☐Yes ☐No Date of last menstrual period:

SURGICAL PROCEDURES

Type of Operation:	Year:

Any other diseases or conditions:

_____

_____

_____

Patient/Responsible Party Signature:_____Date: _____