

Patient Medical History Form

Patient Information

Date ___/___/___

NAME: First _____ Middle _____ Last _____

Address _____ APT/Unit # _____

City _____ State _____ ZIP _____

Home Phone _____ - _____ - _____ Cell _____ - _____ - _____ Work _____ - _____ - _____

EMAIL: _____

Date of Birth ___/___/___ Age _____ Gender: ___ Social Security # ___/___/___

___ Single ___ Married ___ Divorced ___ Child (under 18) _____ Other

Employment Status (___ Full ___ Part ___ Unemployed ___ Retired) Employers Name _____

Pharmacy Name _____ Store # _____ Phone Number ___/___/___

Emergency Contact

Name _____ Relationship to Patient _____

Address _____ Phone _____ - _____ - _____

Insurance Information (In order for us to file a claim on your behalf, this section must be completed entirely)

Medicare ID # (If Applicable) _____ - _____ - _____ - _____ Primary INS _____ Secondary INS _____
--

INSURANCE NAME _____ ID# _____ Group/Acct # _____

Claims Address _____ City _____ State _____ ZIP _____

Claim Phone _____ - _____ - _____

*Subscribers/ Insured Parties Name (if different from above) _____ Date of Birth _____

*Relationship to Patient _____

How did you hear about our practice?

Doctor _____

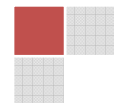
Ad _____

Insurance _____

Website _____

Friend _____

Other _____



Patient Medical History Form

(PATIENT INITIALS _____)

***NOTE:** Please **PRINT CLEARLY** and fill out the sections below as completely as possible.

Reason for Today's Visit:

Allergies: (Please circle or add any allergies you have)

_____ **No Known Drug Allergies**

Ace Inhibitors	Codeine	Lidocaine	Sulfa Drugs
Aspirin	Epinephrine	Marcaine	Tetracycline
Barbiturates	Iodine	Morphine	Tegretol
Cephalosporin	Kenalog	Penicillin	OTHER _____

_____ **No Medications**

List Medications: you are currently taking, this includes over the counter medications such as aspirin.

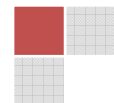
***NOTE:** If you have a **Long Written Copy of your Medications and Surgeries Available**, we will be happy to make a copy of it for you, in lieu of writing them down.

1 _____ 2 _____ 3 _____
4 _____ 5 _____ 6 _____

Surgeries: (Please circle any surgeries you've had and write the year)

_____ **No Surgeries**

Type	Year	Type	Year
AAA	_____	Colon resection	_____
Amputation	_____	Colonoscopy	_____
Angioplasty	_____	Cosmetic surgery	_____
Back surgery	_____	Cyst removal	_____
Biopsy-positive for cancer	_____	Hemorrhoid surgery	_____
Bladder suspension	_____	Hemorrhoidectomy	_____
Breast implant/enhancement surgery	_____	Hip Replacement L R	_____
Breast surgery	_____	Hysterectomy	_____
Breast tumor removal	_____	Knee Replacement L R	_____
C-section	_____	Mastectomy L R	_____
Coronary Artery Bypass Graph	_____	Pacemaker implant	_____
Cardiac catheterization	_____	Prostate surgery	_____
Carotid Enderterectomy	_____	Removal of kidney stones	_____
Carpal tunnel surgery	_____	Vasectomy	_____
Cholecystectomy	_____	Other: _____	_____



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(PATIENT INITIALS _____)

Past Medical History:

(Please circle any medical problems you've had and/or write others)

_____ **No Past Medical History**

- | | | |
|--------------------------|--------------------------|-----------------------------|
| Alcoholism | GI bleed | Osteoporosis |
| Anxiety disorder | Hernia | Peripheral vascular disease |
| Atrial fibrillation | High blood pressure | Pap smear (Date_____) |
| Bladder dysfunction | High cholesterol | Stroke-cardiovascular |
| Congestive heart failure | Hyperlipidemia | Stroke-neurologic |
| Constipation | Hypertension | Stroke-unknown type |
| COPD | Hypothyroidism | Ulcer |
| Depression | Kidney disease | HIV_____ |
| Diabetes | Kidney stones | Hepatitis Form: A B C |
| Eye Exam (Date_____) | Mammogram (Date_____) | Other_____ |
| Gastritis | Mental health condition: | _____ |
| Gastroenteritis | _____ | _____ |
| GERD | Myocardial infarction | _____ |

Family History: (Please circle all that apply and indicate the relative(s))

_____ **No Family History**

Condition	Relatives	Condition	Relatives
Cancer (Type: _____)	_____	Kidney disease	_____
COPD	_____	Leukemia	_____
Diabetes	_____	Lung problems	_____
Glaucoma	_____	Lupus	_____
Heart attack over 50 and older	_____	Obesity	_____
Heart attack under 50	_____	Osteoporosis	_____
Other heart problems	_____	Psychiatric illness	_____
High cholesterol	_____	Stroke	_____
Hypertension	_____	Other: _____	_____

Social History: (Please circle all that apply)

Alcohol Use: None / Social / Mild / Moderate / Heavy / Recovering alcoholic

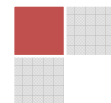
Caffeine Use: None / _____ Servings per Week

Tobacco Use: None / Former User / Current User Packs per Day _____

Prescription Drug Abuse Use: NO / YES Currently Recovering Substance: _____

Illegal Drug Use: NO / YES Currently Recovering Substance: _____

Exercise Regularly: NO / YES Times per Week: _____



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AUTHORIZATION/ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES *A copy of the HIPPA Guidelines can be found in the lobby

I, (Print Patients Name) _____ have read a copy of Oceanside Dermatology, Skin Cancer Surgery and Cosmetic Center's, Notice of Privacy Practices.

X _____

Patient Signature (or Guardian)

X _____

Date

CANCELLATION POLICY

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Oceanside Dermatology reserves the right to charge the patient a \$75 fee if the patient does not cancel the appointment within 24 hours. Additionally, Oceanside Dermatology Skin Cancer Surgery & Center reserves the right to reschedule appointments to which the patient is more than 30 minutes late.

X _____

Patient Signature (or Guardian)

X _____

Date

RELEASE OF MEDICAL INFORMATION

I do / do not (circle one) authorize Oceanside Dermatology and its designated representatives to release medical information to my spouse, parent or guardian.

X _____

Patient Signature (or Guardian)

X _____

Date

CONTACT PERMISSION

In the event that Oceanside Dermatology needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

- Leave a message on an answering machine.
- Speak with spouse / Significant Other / Emergency Contact
- Speak with other family members.
- DO NOT contact anyone else on my behalf.

X _____

Patient Signature (or Guardian)

X _____

Date

AUTHORIZATION / ASSIGNMENT / FINANCIAL

I authorize the release of any medical information necessary to process an insurance claim on my behalf I request that payment under the medical insurance program be made to Oceanside Dermatology & Cosmetic Surgery. I understand that I am financially responsible for all charges.

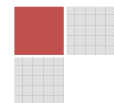
As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred?

X _____

Patient Signature (or Guardian)

X _____

Date



Cosmetic Questionnaire **Optional*

Patients Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ - _____ - _____ Email: _____

I am interested in finding out about:

(Please Check All That Apply)

- Wrinkle Reduction
- Brown/Age Spots/Marks: Removal
- Improvement in Skin Texture
- Acne Correction
- Skin Care Regime best suited for my skin type
- Longer, Thicker Eye Lashes *Latisse
- Lip Enhancement
- Reduce Redness-Skin
- Chemical Facial Peels
- Ear Piercing

Skin Products We Offer:

- SkinMedica
- Remergent
- Revale
- Glytone

Injectibles We Offer:

- Botox

Fillers We Offer:

- Restylane
- Radeisse
- Sculptra
- Juviderm

I would like a Cosmetic Consultation: YES NO

Other Questions: ** Please Specify*

