GULF COAST DERMATOLOGY

PATIENT INFORMATION

PLEASE PRINT USING BLACK INK

PATIENT NAME____DATE OF BIRTH_________________SEX____________

ADDRESS____CITY_________________STATE_______ZIP______________

HOME PHONE(____)___________________WORK PHONE____________________ CELL PHONE________________________

SECONDARY ADDRESS ___________________________________CITY __________________ STATE_______ ZIP_______

SECOND ADDRESS HOME PHONE (____)_______________________MARITAL STATUS___________________________

PATIENT'S SOCIAL SECURITY #____(REQUIRED).

HAVE YOU OR HAS ANYONE IN YOUR FAMILY EVER BEEN SEEN IN OUR PRACTICE BEFORE? YES NO (circle)

IF YES, NAME AND RELATIONSHIP TO YOU____

REFERRING/CONSULTING PHYSICIAN____ PHONE____________________

ADDRESS____

PERSONAL PHYSICIAN____

ADDRESS ____ PHONE _________________________________

NAME OF EMPLOYER____PHONE__________________________________

PRIMARY INSURANCE COMPANY NAME ____

PRIMARY INSURED'S NAME:_____________________________ DOB: __________________SS#_______________________

CONTRACT OR POLICY # ______________________________________ GROUP NUMBER______________________________

SUPPLEMENTAL INS. 1.__________________________________CONTRACT #____

ARE YOU IN ANY WAY AFFILIATED WITH AN HMO YES NO (circle)
IF YES, YOU ARE RESPONSIBLE FOR OBTAINING ANY NECESSARY REFERRALS OR PAYMENT IS DUE AT TIME OF SERVICE.

ARE YOU REQUIRED TO USE A SPECIFIC LAB? _____ YES ______ NO

IF YES, NAME OF LAB ____

PATIENT'S SIGNATURE ____DATE

RELATIONSHIP IF NOT SIGNED BY PATIENT
MINOR MUST BE ACCOMPANIED BY PARENT.

REASON FOR VISIT TODAY - PLEASE CIRCLE
SKIN LESION(S), RASH, ITCHING, ACNE, HAIR, NAIL OTHER

EMAIL ADDRESS: _______________________________________

SEE BACK PAGE

GULF COAST DERMATOLOGY

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment as deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that may be required for the purpose of providing health care services to me, to pay my health care bills, or those that may be required by law.

Signature:____ **Date:** ______________________________

LIFETIME AUTHORIZATION AND ASSIGNMENT

I hereby authorize **GULF COAST DERMATOLOGY** to furnish information to **Medicare / Other Insurance Carriers** concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s) / Medicare to make payment directly to **GULF COAST DERMATOLOGY** for medical / diagnostic / surgical benefits payable for the services rendered.

I understand that I am responsible for any charges incurred if my account is sent to a collection and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.
I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: ____ **Date:** ____________________________
*This must be signed by **ALL** patients, including self pay.

DESIGNATED CONTACTS

Please list the family members, parents, or significant others, if any, whom we may inform about your **medical condition,** and/or in case of an emergency:
Name: ____ Phone #_________________________ Relationship:________________
Name: ____ Phone #_________________________ Relationship:________________
Name: ____ Phone #_________________________ Relationship:________________

PRIVACY NOTICE

Copy of **GULF COAST DERMATOLOGY'S** office privacy notice as required by **HIPPA** available upon request or to visually review in our lobby.

Signature: ____ **Date:** ______________________________________
Patient Name (Print): _______________________________________ **Patient's SS#:**_______________________________

Relationship:____ **Witness:**____________________________________
(If not signed by patient)

***Patients with Power-of-Attorney: We must have a copy of POA paperwork and contact information for our chart.**

Patient Name:_________________________________ Chart #___________Date:____________ Assist:____________

Medications

Please list any and all medications that you are currently taking at this time. This includes over-the-counter pills or vitamins and topical ointments. If you brought a current list of medications with you we will make a copy for our records.

	Name of Drug	Dose	How Often	Reason for Taking
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

This section is for office use only. Will be filled out by assistant.
Any changes since your last visit in:________________________
Please circle Yes or No. If yes, briefly state change.

General Medical Condition Yes No ____

Surgery since last visit Yes No ____

Discontinued any medications Yes No ____

Began new medications Yes No ____

Allergies Yes No ____

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PATIENT___________________________________CHART_____________DATE____________ASSIST____________

(TO BE COMPLETED BY PATIENT) HAVE YOU HAD OR EVER BEEN TOLD YOU HAD ANY OF THE FOLLOWING:

GENERAL MEDICAL HISTORY--CURRENT AND PAST

Personal Physician Name__________________________ Consulting Physician Name____________________________

Other Doctors you are now currently seeing and why

Name: 1._____________________________ _____________________________

2._____________________________ _____________________________

3._____________________________ _____________________________

4._____________________________ _____________________________

5._____________________________ _____________________________

CURRENT MEDICAL PROBLEMS AND REVIEW OF SYSTEMS -

PATIENT - PLEASE CHECK APPROPRIATE LINE IF YOU HAVE THIS PROBLEM

General

_____ Good appetite?
_____ Feel good?
_____ Do you need antibiotic coverage prior to surgery?
_____ Blood Transfusions. If yes, date_______________
_____ History of exposures, infectious disease
_____ Hepatitis
_____ AIDS
_____ HIV
_____ Tattoos
_____ When you are exposed to sunlight do you normally Burn / burn - tan / tan only?
_____ You use sunscreens
_____ Difficulty healing
_____ Scarring / Keloids

Joint replacement

Which joint / date_____________________________
_____ Heart valve replacement

Central Nervous System

_____ Headaches
_____ Dizziness
_____ Ringing in the ears
_____ Seizures
_____ Strokes
_____ TIAs

Psychiatric

_____ Anxiety
_____ Stress disorder
_____ Claustrophobic

Bleeding Disorders / Blood

_____ Have you ever had severe bleeding after any type of dental work, surgery, accident or cut?
_____ Anemia

Pulmonary / Lung

_____ COPD
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis
_____Asthma

Cardiac / Heart/ Vascular

_____ Heart attack
_____ Chest pains
_____ Shortness of breath
_____ Pacemaker
_____ High Blood Pressure
_____ Irregular heart beat or arrhythmia
_____ High cholesterol

Endocrine Disease (Gland)

_____ Thyroid
_____ Diabetes

Gastrointestinal (Stomach)

_____ Stomach pains
_____ Ulcers, Colitis, Black or Red stool

GYN (if applicable)

_____ Normal periods
Date of last pregnancy ________________________
_____ Currently Pregnant
_____ Immune suppressed

Eyes

_____ Fuzzy vision _____ Double vision
_____ Blindness
_____ Glasses _____ Contact lenses
_____ Glaucoma

Genitourinary (Kidney)

_____ Difficulty with urination

Liver Disease

_____ Hepatitis
_____ Cirrhosis

Rheumatology/Muscles/Joints

_____ Chronic arthritis
_____ Joint aches _____ Muscle aches
_____ Lupus, Scleroderma, Connective Tissue Disease

Accidents

_____ Car _____Work

Cancer

_____ Cancer location and date:
1.______________________________
2.______________________________

SEE BACK PAGE

PATIENT________________________________CHART____________DATE___________ASSIST_________

SOCIAL HISTORY, WORK HISTORY, HOBBIES

__Yes__No: Do you smoke or did you ever smoke?
__Yes__No: Do you drink?
__Yes__No: Occupation or past occupation _______________________________________
__Yes__No: Hobbies. Please circle.
Gardening, golf, tennis, swimming, fishing, other_________________________
_Yes_No: Pets__________________________________
_Yes_No: Any exposure to chemicals that you are aware of?

Where were you born?____
Where did you live most of your adult life?__________________________
How long have you lived in Florida?_______________________________

FAMILY HISTORY

_Yes__No: Skin disease, allergies, allergic disease, diabetes, bleeding disorder, skin cancer?
Skin Disease / Cancer
__Yes__No: Parents ___________________________
__Yes__No: Brother / Sister ____________________
__Yes__No: Children _________________________

CANCER LOCATION DATE

1.______________________________________

2.______________________________________

3.______________________________________

PAST ILLNESSES:

1.______________________________________

2. ______________________________________

3. ______________________________________

PAST SURGERIES:

1.______________________________________

2.______________________________________

3.______________________________________

ALLERGIES

_YES_NO: SKIN ALLERGIES?
_YES_NO: HAY FEVER?
_YES_NO: ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE LIST

NAME DATE REACTION

1. ____
2. ____
3. ____

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