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SkinSmart Dermatology™

Medical Dermatology

MOHS Skin Cancer Surgery

Cosmetic Dermatology

skinsmartdermatology.com

Patient Legal Name		Date of Birth	Age	Sex	Social Security Number (REQUIRED)	
Primary Address		City	State		Zip Code	Home () Work () Cell ()
Summer Address		City	State		Zip Code	Home
If Minor, Legal Guardian's Name						
Emergency Contact		Relationship		Emergency Contact Number		

Uninsured method of payment: <input type="checkbox"/> Cash <input type="checkbox"/> Credit (Visa, Amex, MasterCard) <input type="checkbox"/> CareCredit			
Primary Insurance: _____		Secondary Insurance: _____	
Subscriber ID:	Insured's Name	Subscriber ID:	Insured's Name
Relationship to Patient	Date of Birth	Relationship to Patient	Date of Birth
Name of Primary Care Physician			
		Phone:	Fax:
Name of Referring Doctor			
		Phone:	Fax:

How did you hear about our office? (Please check all that apply)	<input type="checkbox"/> Doctor _____	<input type="checkbox"/> Internet	<input type="checkbox"/> Staff
	<input type="checkbox"/> Patient _____	<input type="checkbox"/> Drive-By	<input type="checkbox"/> Screening Event
	<input type="checkbox"/> Insurance/Insurance Website	<input type="checkbox"/> Event	<input type="checkbox"/> Magazine _____
	<input type="checkbox"/> Physician's Guide	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Other _____
<input type="checkbox"/> Yes, I wish to receive occasional SkinSmart Dermatology news and service/product updates.			
Email Address: _____			
<small>SkinSmart does not sell, share, rent, or disclose your information as it is for internal office use only. By checking the box, you give us permission to add you to our mailing list.</small>			

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to Elizabeth F. Callahan, MD or SkinSmart Dermatology. **Any pathology and laboratory fees are billed independently of SkinSmart Dermatology and are ultimately the patient's responsibility.**

Payment is required for all services at the time they are rendered. **All applicable co payments and deductibles will be collected at the time of service.** Our terms are net 30 days. Appointments that are not cancelled 24 hours prior to the appointment time may be charged a \$25 fee. Your signature below signifies your understanding and willingness to comply with this policy.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, copays, coinsurances and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of service provided.

Signature of Patient or Legal Guardian _____ Date _____

Patient _____ DOB _____ Age _____ Today's Date _____

Primary Care Physician: _____

List all medications you are currently taking, including over the counter medications, vitamins, and natural or holistic remedies. Include Dose and how often you take it.

Please list all Allergies to Medicines:

Medication: _____ Reaction: _____

Please check yes or no of appropriate box of medical conditions you had or currently are experiencing (attach sheet if necessary):

	YES	NO		YES	NO
History of Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Need antibiotics prior		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	to dental cleanings?	<input type="checkbox"/>	<input type="checkbox"/> If yes, why? _____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Varicose or spider leg veins	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain, aching, cramping	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Vein Ultrasound in past 12 mo?	<input type="checkbox"/>	<input type="checkbox"/>

Please list any skin cancers and location(s): _____

Please list any other diseases or conditions: _____

Major surgeries by date in the last 5 years: _____

Hospitalizations in the last 5 years: _____

Social History: Occupation: _____

Do you smoke? No Former Yes: How many packs per day? _____

Do you drink? No Former Yes: How many drinks per day? _____

Women ONLY: Are you pregnant? Yes No Trying to get pregnant? Yes No Breast feeding? Yes No

Are you on Birth Control? Yes No Are you post menopausal? Yes No

Family History: Melanoma: who? _____ Basal or Squamous cell skin cancer: who? _____

X _____ X _____
Signature of Patient Date Signature of Medical Provider Date

MOHS Consultation Patients ONLY

Location of the growth to be removed? _____ Is it growing? Yes No

How long has the growth been present? _____ How the growth been treated previously? _____

Does the growth do the following: **Bleed?** Yes No **Ulcerate?** Yes No **Tingle?** Yes No

Do you have a history of: **X-Ray treatments for acne** Yes No **Chronic Scarring** Yes No

Immunosuppression Yes No