

Advanced * Dermatology

111 Salem Turnpike, Suite #7
Norwich, Connecticut 06360

Patient Demographic Sheet

Date _____
Patient's Name: _____ Gender: _____ Marital Status: S M W D
Date of Birth: _____ Race/Ethnicity: _____ Language: _____
Address: _____ E-mail: _____
City: _____ State: _____ Zip: _____
Tele #: Primary: _____ Secondary#: _____
Employer: _____
Family MD/Address: _____ / _____
Referring MD/Address: _____ / _____
Preferred Pharmacy/Location: _____ / _____

****PLEASE FILL IN ALL INSURANCE INFORMATION BELOW****

Name of Primary Insurance : _____
Identification#: _____ Group# _____
Name of person who holds the insurance policy: _____
Relationship to Patient: _____ SS#: _____ Date of Birth: _____

Name of Secondary Insurance Company: _____
Identification#: _____ Group# _____
Name of person who holds the insurance policy: _____
Relationship to Patient: _____ SS#: _____ Date of Birth: _____

**** Parent/Guardian: Name and Address (if different than above)****

Name: _____
Address: _____ Tele #: _____

Please list any spouse, family member, caregiver, and/or friend who Advanced Dermatology can speak with regarding your care, biopsy results, appointments, etc.

If we may only speak with you, please cross this section out

Name: _____ Your Initials: _____

Emergency Contact: _____ Tele #: _____

History and Intake Form

Patient Name: _____

DOB: _____

AGE: _____

Main reason you are here today: _____

Past Medical History: (please **circle** all that apply)

Arthritis	Diabetes	Leukemia/ Lymphoma
Asthma	End Stage Renal Disease	Radiation Treatment
Atrial fibrillation	Hearing Loss	Stroke
Bone Marrow Transplantation	Hepatitis	Heart Murmur
Breast Cancer	High Blood pressure	Mitral Valve Prolapse
COPD (Lung Disease)	HIV/AIDS	NONE
Coronary Artery Disease	Hyperthyroid	
Depression	Hypothyroid	

Other: _____

Past Surgical History: (please **circle** all that apply)

Coronary Artery Bypass/ Stents/ Angioplasty	Joint Replacement: Hip (Right, Left, Both)
Heart Valve Replacement/ Repair	Joint Replacement: Knee (Right Left, Both)
Organ Transplant (Heart/ Kidney/ Liver)	Spleen Removed
Pacemaker	NONE
Internal Heart Defibrillator	

Other: _____

Skin Disease History: (please **circle** all that apply)

Actinic Keratoses	Melanoma	Psoriasis
Blistering Sunburns	Eczema	Ultraviolet Light Treatments
Basal Cell Skin Cancer	Hay Fever/Allergies	NONE
Squamous Cell Skin Cancer	Precancerous Moles	

Other: _____

Do you tan in a tanning salon? Yes No

Family History (Only first degree relatives. Circle all that apply.)

Psoriasis Melanoma Eczema

Medications: (Please enter all current medications)

NONE

Allergies to Medications:

NONE

Cigarette Smoking:

Alcohol Use:

- Never Smoked
- Former Smoker
- Currently Smokes

- None
- less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Occupation: _____

ALERTS: (please circle all that apply)

- Allergy to adhesive
- Allergy to latex
- Allergy to topical antibiotics
- Allergy to lidocaine
- Require antibiotics prior to a surgical procedure
- Rapid heartbeat with epinephrine

- Defibrillator
- Heart Murmur
- Artificial heart valve
- Artificial joint replacement
- Pacemaker
- MRSA (methicillin resistant staphylococcus aureus)

Are you pregnant or currently trying to get pregnant?

Review of Systems: Please circle any that you are **currently** experiencing:

- Problems with bleeding
- Rash
- Chest Pain
- Unintentional Weight Loss
- Blurry Vision
- Bloody Urine
- Neck Stiffness
- Cough
- Anxiety

- Problems with healing
- Immunosuppression
- Fever and Chills
- Thyroid Problems
- Abdominal Pain
- Joint Aches
- Headaches
- Shortness of Breath
- Depression

- Problems with scarring
- Hay Fever
- Night Sweats
- Sore Throat
- Bloody Stool
- Muscle Weakness
- Seizures
- Wheezing

SIGNATURE: _____ DATE: _____

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Release of Information and Authorization of Benefits

Patient Name: _____ Account #: _____

I authorize Advanced Dermatology, L.L.C. to release medical information, or anything pertaining to the examination, treatment, history, and medical expenses including preexisting condition information to my insurance companies and/or its acting intermediary or agent, or employer/compensation carrier(s), or its legal representative for the purpose of processing insurance claims. This release may include reviewing and/or photocopying pertinent documents for the purpose of payment by your insurance company.

I authorize release of medical information to physicians or health practitioners (for example, Physical therapists) to whom I may be referred.

I authorize payment of medical insurance benefits* to be made directly to Advanced Dermatology, L.L.C. I permit a copy of this authorization to be used in place of the original.

I understand that it is my responsibility to ensure Advanced Dermatology, L.L.C. participates with my insurance. Advanced Dermatology requires a 24-hour advanced cancellation notice, failure to notify the office will result in a \$25.00 no show fee effective June 1, 2004.

I agree to accept full financial responsibility for payment of charges for services rendered. I further agree to pay the cost of collections and/or attorney's fees in the event this account is referred to a collection agency or attorney.

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with an effective date of June 1, 2004.

Patient or Guarantor Signature

Date

If guarantor, indicate relationship to patient

*For Medicare patients, this applies to The Social Security Administration or its intermediaries, or carriers. *For Blue Shield of Connecticut, this applies to a covered service rendered by a participating physician only.