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? (circle) YES NO

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? (circle) YES NO
IF YES, YOU ARE RESPONSIBLE FOR OBTAINING ANY NECESSARY REFERRALS OR PAYMENT IS DUE AT TIME OF SERVICE. *(Initials)* _____

ARE YOU REQUIRED TO USE A SPECIFIC LAB? (circle) YES NO *(Initials)* _____

IF YES, NAME OF LAB _____

I ALSO ACKNOWLEDGE I AM RESPONSIBLE TO INFORM GULF COAST DERMATOLOGY, DR HAMILL OR ASSOCIATES OF ANY CHANGE IN MY HEALTH INSURANCE STATUS PRIOR TO MY NEXT VISIT. *(Initials)* _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP_____ *(Initials)* _____

PATIENT'S SIGNATURE _____ DATE _____

RELATIONSHIP IF NOT SIGNED BY PATIENT _____
MINOR MUST BE ACCOMPANIED BY PARENT. *(Initials)* _____

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

EMAIL ADDRESS: _____

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GULF COAST DERMATOLOGY
PATIENT CONSENT FOR USE, DISCLOSURE OR REQUEST OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

Patient Name:_____

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for services information. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your healthcare
- Submit your diagnosis and treatment information for payment from insurance companies or others

"ONLY AS PERMITTED BY STATE OR FEDERAL LAW", you are giving this practice CONSENT to do the following:

- **To disclose, as may be necessary, your protected health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.**

- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.**

- **To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to insurance company/s, other agencies and/or individual(s) for payment of our services.**

- **To leave appointment reminders or information we believe necessary for your treatment or payment on your answering machine or with a member of your household. The information will be the minimum necessary in our professional judgment.**

- **To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.**

- **If you choose, please list by name and relationship of persons with whom we may share your healthcare or payment information**_____

- You may request a copy of, or as a new patient, will be given a copy of our ***"Notice of Patient Privacy Practices"*** that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have read or have had the right to read the ***"Patient Health Information Privacy Practices"*** prior to signing this consent.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

_____	_____	_____
Signature	Print name of person signing	Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP_____. If you are not the parent, please provide a copy of your legal authority for this patient.

FOR OFFICE USE ONLY

Patient refused to sign the consent form. Reason:_____ Date:_____

Date_____

Patient Name _____ Date of Birth _____

PAST MEDICAL HISTORY

Please Circle if you currently have or in the past have had any of the following medical conditions.

Anxiety	Colon Cancer	Hearing Loss	Lung Cancer
Arthritis	COPD	Hepatitis	Lymphoma
Asthma	Coronary Artery Disease	Hypertension	Prostate Cancer
Atrial Fibrillation	Depression	Elevated Cholesterol	Radiation Treatment
Enlarged Prostate	Diabetes	Hyperthyroidism	Seizures
Bone Marrow Transplant	Kidney Disease	Hypothyroidism	Stroke
Breast Cancer	GERD	Leukemia	HIV/AIDS
Blood Clots			

PAST SURGICAL HISTORY

What operations have you had? _____

_____

SKIN DISEASE HISTORY

Please circle if you have had any of the following skin or skin-related conditions:

Acne	Dry Skin	Poison Ivy
Actinic Keratosis/precancers	Eczema	Irregular/Atypical or Dysplastic lesions
Asthma	Itchy/Flaking Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Do you wear sunscreen: _____yes _____no If yes what SPF? _____

Do you or have you ever tanned in a tanning salon _____ yes _____no

over →

FAMILY HISTORY
Has anyone in your family had melanoma? _____yes _____no
If yes, which relative_____

Drug Allergies (please enter) _____
_____

SOCIAL HISTORY (Please circle one)

Alcohol Use

Yes _____ No _____ 1 drink daily _____ 2 to 3 drinks daily _____ over 4 drinks daily _____

Cigarette Smoking
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Occupation and Workplace _____

Place of Residence (state)_____

REVIEW OF SYSTEMS

Please circle if you are currently experiencing any of the following:

I do not have any of these problems_____

Allergy to lidocaine/ epinephrine

Problems with bleeding

Problems with scarring (keloids)

Immunosuppression

Artificial joints within the past two years

Artificial Heart valve

Premedication prior to procedures

Blood thinners

Pacemaker

Defibrillator

Latex allergy

Allergy to adhesive

MRSA

Allergy to topical antibiotic ointments

Pregnancy or planning a pregnancy

Rash

Thyroid Problems

Headaches

Seizures

Cough

Shortness of breath

Anxiety

Depression

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Additional Patient Information

Language:

English

Spanish

other: _____

Race:

White

Black/African American

Asian

American Indian or Native Alaskan

Native Hawaiian/Pacific Islander

Ethnicity:

Hispanic/Latino

Not-Hispanic/Latino

Pharmacy: Name:_____

Street_____Zipcode: _____

Phone Number _____

Patient Name:_____Chart #_____ Date_____

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				
13				
14				
15				

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