PERRY
DERMATOLOGY

NEW PATIENT PAPERWORK

Date: ___/____/_____ Name:_____ DOB: ___/___/_____

Reason for today's visit:_____
Is your current skin condition: (please circle) Bleeding Itching Painful Growing Changing
Duration of skin condition: _____ Location :_____
Have you tried any medications in the past for your skin condition? Y/N
If yes, please list: _____
Primary Care Physician/Practice: _____
Pharmacy Name/Phone/Address:_____

Additional Screening: (PLEASE CIRCLE):
HISTORY OF SEVERE/BLISTERING SUNBURN: Y / N ATYPICAL MOLES: Y / N
FAMILY HISTORY OF SKIN CANCER: Y / N IMMUNOSUPPRESSION: Y / N

PERSONAL MEDICAL HISTORY

Please mark yes for any medical conditions you have or have had in the past:

Basal Cell Skin Cancer	Y / N	HIV/AIDS	Y / N
Squamous Cell Skin Cancer	Y / N	Hepatitis C/Liver Disease	Y / N
Actinic Keratosis	Y / N	Thyroid Disorders	Y / N
Melanoma	Y / N	Diabetes	Y / N
Psoriasis	Y / N	Kidney Disease	Y / N
Eczema	Y / N	High Blood Pressure	Y / N
Rosacea	Y / N	Heart Attack or Stroke	Y / N
Cancer (please specify if yes):	Y / N	Pacemaker/ Defibrillator	Y / N
Seasonal Allergies/Hay Fever	Y / N	Artificial Heart Valve	Y / N
Asthma	Y / N	Organ/Bone Marrow Transplant	Y / N
Keloid	Y / N	Artificial Joint in Last 2 years	Y / N
Autoimmune Disease	Y / N	Anesthetic Complications	Y / N

Are you currently pregnant, planning to become pregnant, or breastfeeding?
_____

SOCIAL HISTORY

Tobacco Use: Current Former Never If current, how many per day? _____
Alcohol Use: Current Former Never If current, how many per day? _____
Occupation: _____

MEDICATIONS AND ALLERGIES

Please list any current medications:

_____
_____
_____

Please list any allergies:

_____
_____
_____

REVIEW OF SYSTEMS

Please circle any symptoms you are currently having:

Fever, Chills, Nausea, Vomiting, Diarrhea, Constipation, Chest Pain, Shortness of Breath, Cough, Headaches, Numbness, Joint Pain, Changes in Vision, Unintended Weight Loss, Anxiety, Depression, Easy Bruising/Bleeding, Painful Urination

FAMILY MEDICAL HISTORY

If any of your blood relatives have or had a condition listed below, please circle Y (Yes) and specify which relative.

Eczema	Y/N	Psoriasis	Y/N
Asthma	Y/N	Basal Cell Carcinoma	Y/N
Diabetes	Y/N	Squamous Cell Carcinoma	Y/N
Heart Disease	Y/N	Melanoma	Y/N
Acne	Y/N	Other Cancer	Y/N
Autoimmune Disease	Y/N	Other: _____	

DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: ___/___/_____
Mailing Address: _____
City/State/Zip: _____
Home Phone: _____ Mobile: _____ Work: _____
Email Address: _____
Preferred Method of Contact: _____
May we send you appointment reminders via text? Y / N

Gender: M / F Race: Cau/Hisp/AfrAm/Asian/Other/Decline
Marital Status: Single/Married/Divorced/Separated/Widowed

Emergency Contact Name _____
Phone Number: _____ Relationship to Patient:_____

INSURANCE INFORMATION

Please allow the receptionist to make copies of your insurance cards and driver's license. If you don't have your cards or are not the primary policy holder, please fill in the information below, including policy holder name, relationship, and date of birth.

Primary Insurance: _____ ID# _____
Policy Holder Name: _____ Policy Holder DOB: ___/___/_____
Relationship to Policy Holder: (Circle one) Self Spouse Child

Secondary Insurance: _____ ID# _____
Policy Holder Name: _____ Policy Holder DOB: ___/___/_____
Relationship to Policy Holder: (Circle one) Self Spouse Child

Guarantor Information
Person Responsible for Payment: (Circle one) Self Spouse Parent Other
Please fill out below guarantor is someone other than self:
Name: _____
Address: _____
City/State/Zip: _____
Phone Number: _____

OFFICE POLICIES

Insurance claims will be filed for all medically necessary services if the office is credentialed with your insurance company. Copayments, previous balances, and self pay fees are due at the time of service. For any returned checks, there will be a $25 NSF fee that will be added to your account. Accounts that have a credit of less than $5 will not be refunded unless requested, but will remain in your account for future use.

If you are unable to make your scheduled appointment, we ask that you notify the office no later than 24 hours prior to your appointment. If you arrive 20 minutes or later after your scheduled appointment time, your appointment may be rescheduled. If we are able to keep your original appointment, you may have to wait longer than usual. We try our best to see patients in a prompt and timely manner. For patients who no-show to an excision/surgery appointment without canceling 24 hours prior to the procedure appointment, we reserve the right to apply a $75 charge.

- I hereby request the professional services of Perry Dermatology and have read and understand the above.
- I authorize payments to Perry Dermatology by my insurance company for all services rendered to me or to my dependents.
- I understand that I am financially responsible for all charges, whether or not paid by my insurance.
- I authorize the physician to release any information for my medical care or for insurance purposes as outlined in the Notice of Privacy Practices that I have received.
- I authorize the use of this signature on all insurance submissions.
- This authorization is in effect until terminated by the patient.
- I authorize the office to obtain prescription formulary information and information about other prescriptions given to me by other providers.
- I authorize this office to e-prescribe prescriptions on my behalf.

I authorize my medical information to be shared with the following persons:

Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____

Signature of Patient or Legal Guardian:

_____ Date: _____