Patient Information Sheet

Dermatology SouthEast
ST. JOHNS

Physician:____________
Account: ____________
Date: ________________

PLEASE PRINT

Name of Patient ____ Age __________
(Last) (First) (Middle)

Date of Birth ____________________ SS# ______________________ Sex ________ Marital Status ______________

Mailing Address ____
(Street/PO Box) (Apt #) (City) (State) (Zip)

Best Daytime Contact Phone Number	**Evening Phone Number**	**Alternate Phone Number**
______________________	______________________	______________________
☐ **Cell** ☐ **Home** ☐ **Work**	☐ **Cell** ☐ **Home** ☐ **Work**	☐ **Cell** ☐ **Home** ☐ **Work**

Email Address ____

Emergency Contact (not living with you) ____
(Name) (Relationship) (Phone Number)

Primary Care Physician ____
(Name) (City/State)

Occupation/Previous Occupation ____ Retired: ☐ Yes ☐ No

Patient's Employer ____
(If child, give parents information) (Name) (City/State)

The Federal Government requests that we collect the following information:

Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Type-Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Type-Unknown **Preferred Language:** ______________________

It is the policy of this practice to collect payment at time of service.

Primary Insurance (please circle) **Policy #**______________________________
FL Blue Cross/Shield PPC/PPO Medicare Coventry Health Care United Health Care Other______________

Secondary Insurance (please circle) **Policy #** ______________________________
FL Blue Cross/Shield PPC/PPO Medicare Coventry Health Care United Health Care Other______________

Name of Policy Holder: ______________________________ **Policy Holder Date of Birth:** ______________

OVER

MEDICAL HISTORY

Do you have any of the following health problems? **Please check all that apply.**

☐ Basal/ Squamous Cell Skin Cancer	☐ Diabetes	☐ Joint replacement or hardware
☐ Melanoma Skin Cancer	☐ Hepatitis B/C	☐ Lupus
☐ Atypical Moles	☐ HIV	☐ Lymphoma
☐ Sun Sensitivity	☐ Tuberculosis	☐ Leukemia
☐ Dry/Sensitive Skin	☐ Pacemaker	☐ Organ transplant
☐ Cancer (Non-Skin Cancer)	☐ Artificial Heart Valve	☐ Stroke
☐ Psychiatric Problems	☐ Taking Blood Thinners	☐ Heart Attack

Are you pregnant? ☐ Yes ☐ No **If yes, notify nurse**

Current smoking status: ☐ Smoke every day ☐ Smoke sometimes ☐ Former smoker ☐ Never smoked

ALLERGIES: Are you allergic to any medications? ☐ Yes ☐ No **If yes, list medication and the reaction you had:**

____

____

CURRENT MEDICATIONS: (list all medications and dosage you take on a regular basis or every once in a while):

__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

OTHER MAJOR MEDICAL PROBLEMS/ OPERATIONS/ HOSPITALIZATIONS: ____________________

____

____

REASON FOR SEEING DOCTOR TODAY: ______________________________

____

____

Have you sought care for this problem elsewhere? ☐ Yes ☐ No If yes, where? ______________________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS FOR PHYSICIANS.

COMMERCIAL INSURANCE

I hereby authorize the release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO DERMATOLOGY SOUTHEAST. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature (patient or guardian) ____

MEDICARE INSURANCE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Southeast for any services furnished to me by Dermatology Southeast. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services.

Signature (patient or guardian) ____