

PATIENT INFORMATION RECORD

PLEASE PRINT

Date: \_\_\_\_\_

Have you been a patient at our clinic before? NO  YES  When? \_\_\_\_\_

Please answer each item. If an item does not pertain to you, indicate so with a check (✓).

PATIENT'S

Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
LAST FIRST MIDDLE

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ SS # \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

WHO WILL BE RESPONSIBLE FOR THE PATIENT'S MEDICAL EXPENSES?

Check One:  Patient  Spouse  Mother  Father  Other \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ SS # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

INSURANCE INFORMATION:

★ ★ ★

Primary Carrier \_\_\_\_\_ Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_

Insured's I. D. # \_\_\_\_\_ Group # \_\_\_\_\_ Family Coverage  Yes  No

Patient's Relationship to Insured:  self  spouse  child  other Visit Copay Amount \_\_\_\_\_

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Secondary Carrier \_\_\_\_\_ Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_

Insured's I. D. # \_\_\_\_\_ Group # \_\_\_\_\_ Family Coverage  Yes  No

Patient's Relationship to Insured:  self  spouse  child  other Visit Copay Amount \_\_\_\_\_

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. I understand I am financially responsible for charges not covered by my insurance. I further authorize:

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier information needed to determine benefits.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY ME IN WRITING.

X  
SIGNATURE OF PATIENT OR PARENT IF MINOR \_\_\_\_\_ Date \_\_\_\_\_

In Case of Emergency, Notify \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) Relationship \_\_\_\_\_

How were you referred to the Clinic? \_\_\_\_\_

May we have your permission to leave medical information on your voicemail or machine?  Yes  No What number? \_\_\_\_\_

List the name of anyone with whom we may discuss your medical information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

# Tulsa Dermatology Clinic, Inc.

2121 East 21<sup>st</sup> Street • P.O. Box 52588 • Tulsa, OK 74152 • 918-749-2261

## MEDICAL HISTORY

- Heart attack     Heart Disease     Stroke     High Blood Pressure     Stomach Ulcers     Diabetes     Hepatitis  
 Cancer (type/date) \_\_\_\_\_     Bleeding Disorder     Multiple Sclerosis     Lupus     HIV/AIDS  
 Skin Cancer (type/location/date) \_\_\_\_\_  
 Atypical mole (location) \_\_\_\_\_     Other \_\_\_\_\_

## PLEASE LIST ANY SURGERIES

- Bypass     Hip/Knee Replacement     Pacemaker/Defibrillator     Other \_\_\_\_\_

Are you required to take antibiotics before dental procedures?     Yes     No

## FAMILY HISTORY

Do you have a family history of melanoma?     Yes     No    If yes, which family member? \_\_\_\_\_

## SOCIAL HISTORY

Do you smoke?     Yes     No

## TO ENSURE PROPER TREATMENT, PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY USING:

Name of Medication	Strength/mg.	How often?	Purpose

Are you allergic to any medications?     Yes     No    If yes, please list below.

Drug: \_\_\_\_\_    Reaction: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## REVIEW OF SYSTEMS: Circle any that apply

**General:** Fever    Chills    Malaise    Night Sweats    Weight loss    NONE    **Musculoskeletal:** Joint pain    Swelling of the legs    NONE  
**Psychological:** Depression    Anxiety    NONE    **Eyes:** Tearing    Dryness    Irritation    Cataracts    Glaucoma    NONE

Are you pregnant?     Yes     No    Nursing?     Yes     No    Any other problems? \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*I may refuse to sign this acknowledgement.*

Date: \_\_\_\_\_

I have received a copy of Tulsa Dermatology Clinic, Inc.'s Notice of Privacy Practices.

X

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

## Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual Refused to Sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: \_\_\_\_\_

I have reviewed the above information: \_\_\_\_\_    \_\_\_\_\_    Attending Physician's Signature