

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 _____

★ ★ ★

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 _____

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: _____

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 _____ Date _____
 SIGNATURE OF PATIENT OR PARENT IF MINOR

Tulsa Dermatology Clinic, Inc.

2121 East 21st 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