

PATIENT INFORMATION

Please write **CLEARLY** and include any apt. #'s, etc., * Required information

Today's Date: _____

*Last Name: _____

*First Name: _____

*Sex: M F

*SS#: _____

*Date of birth: _____

*Email: _____

*Street Address: _____

*City, State, Zip Code: _____

* Emergency Name and Phone: _____ Relationship: _____

Primary Care Physician (name & phone #): _____

Referring doctor (if applicable): _____

How Did You Find Us? (friend, AD, Web): _____

PHARMACY INFORMATION: Name (with Street name, Zip code and phone- if known)

PRIMARY INSURANCE INFORMATION

Insurance Carrier: _____ (PPO or HMO) Ins Copay: _____

Guarantor/Subscriber's Name: _____ Subscriber's ID#/SS#: _____

Guarantor's Relationship to Patient: _____ Ins. Primary Phone: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ (PPO or HMO) Ins Copay: _____

Guarantor/Subscriber's Name: _____ Subscriber's ID#/SS#: _____

Guarantor's Relationship to Patient: _____ Insurance Phone: _____

SIGNATURE ON FILE AND FINANCIAL AGREEMENT

I _____, acknowledge that MedDerm Associates, Inc. will bill the insurance company that I have provided information about on the day of my visit as a courtesy to me. However, as a patient, I am ultimately responsible for my medical bills if, for whatever reason, I become ineligible with this insurance company at the time of service, or if my insurance company denies payment for a procedure or service provided to me by MedDerm Associates, Inc.

Signature

Date

PRIVACY PRACTICES – HIPAA

Last Name: _____ **First Name:** _____

Date of Birth: _____

_____ I acknowledge that I can request a copy of the Notice of Privacy Practices that MedDerm Associates, Inc. has implemented.

_____ I acknowledge that MedDerm Associates, Inc. will keep a record of the health care services they provide for me. I may see and copy that record, and I may ask to correct the record if need arises.

_____ I am aware that MedDerm Associates, Inc. may disclose my health information to a physician or healthcare provider providing treatment to me, or to my insurance company to obtain payment for services. I acknowledge that MedDerm Associates, Inc. will not disclose any of my records unless I direct them to do so or unless the law authorizes or compels them to do so.

_____ I am aware that I may see my record or get more information about it by contacting:

MedDerm Associates, Inc.
501 Washington St, Suite 502
San Diego, CA 92103
Tel# 619-542-0013

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access that information.

By my signature below, I acknowledge receipt of this Notice of Privacy Practices.

Signature of patient or authorized representative.

Date

Printed name of representative signing on behalf of patient

Relationship to patient

CLINICAL TRIALS

MedDerm is involved in clinical research trials aimed at advancing and refining dermatologic therapeutics.

Would you (or your child) like to be contacted for clinical trials in the future?

Yes, please contact me (or my child) about a clinical trial for the following condition(S):

Psoriasis

Acne

Eczema

Rosacea

Lupus

Actinic Keratosis

Nail Fungus

Cosmetic Therapies

other _____

No thank you.

Not sure

Name: _____ Date of Birth: _____

MEDICATIONS AND MEDICATION ALLERGIES

Allergies to Medications (pills, injectable drugs, creams, etc):

Please list all of your oral and topical medications. Include over the counter medications that you use regularly, vitamins, minerals, herbal and other dietary supplements.

SOCIAL HABITS

Tobacco history: Current every day smoker Current some day smoker Former smoker Never smoker
 Smoker current status unknown Unknown if ever smoked

Alcohol use: NO YES: Amount _____ Frequency _____ Quit _____

Street drugs: NO YES: Marijuana _____ Methamphetamine _____ Other _____

PERSONAL SKIN HISTORY

* Please note **Y** or **N**

- | | | |
|-----|---------------------------------|-----------------------------------|
| Y N | | Y N |
| Y N | Actinic keratosis ("precancer") | Y N Lupus erythematosus |
| Y N | Acne | Y N Melanoma: yr _____ site _____ |
| Y N | Basal Cell Carcinoma | Y N Psoriasis |
| Y N | Excessive hair growth | Y N Pigmentary problems |
| Y N | Excessive sweating | Y N Rosacea |
| Y N | Eczema | Y N Squamous Cell Carcinoma |
| Y N | Hair loss | Y N Keloid scarring |

FAMILY HISTORY

Is there a family history of the following conditions:

- Y N
- Actinic keratosis ("precancer")
 - Y N Acne
 - Y N Basal Cell Carcinoma
 - Y N Excessive hair growth
 - Y N Excessive sweating
 - Y N Eczema
 - Y N Hair loss
 - Y N Keloid scarring
 - Y N Lupus erythematosus
 - Y N Melanoma
 - Y N Psoriasis
 - Y N Pigmentary problems
 - Y N Rheumatoid arthritis
 - Y N Rosacea
 - Y N Squamous Cell Carcinoma

Other Family History (skin or general): _____

GENERAL MEDICAL HISTORY

Please list medical problems, illnesses and major diagnoses in the left column and surgeries and other procedures in the column on the right.

DATE	PROBLEMS, ILLNESSES AND MAJOR DIAGNOSES	SURGERIES AND OTHER PROCEDURES

CURRENT SKIN PROBLEM(S) - Reason for visit)?

1. _____
 - a. Length of time (with issue) _____
 - b. Site _____
 - c. Past treatment _____
 - d. Severity _____
 - e. Other _____

2. _____
 - a. Length of time (with issue) _____
 - b. Site _____
 - c. Past treatment _____
 - d. Severity _____
 - Other _____

SYMPTOM REVIEW

Are you having problems in these areas currently (or circle No)?

- Allergic _____ No
- Bleeding _____ No
- Breathing _____ No
- Heart _____ No
- Weight loss/gain _____ No
- Fevers, chills, sweats _____ No
- Thyroid/other endocrine _____ No
- Eye _____ No
- Stomach (GI) _____ No
- Female reproductive organs _____ No
- Male reproductive organs _____ No
- Joint/Back/Neck _____ No
- Neurologic _____ No
- Mood/Psychiatric _____ No
- Ears/Nose/Throat _____ No
- Other _____ No