MedDerm Associates, Inc.

PATIENT INFORMATION

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

Today's Date: _____

***Last Name:** _____

***First Name:** _____ ***Primary phone:** _____

***Sex:** ■ M □ F **Marital Status:** ◉ S ○ M ○ W ○ D ○ DP

***SS#:** _____ ***Race :** _____or (REFUSE TO REPORT)

***Date of birth:** _____ ***Ethnicity:** _____or (REFUSE TO REPORT)

***Email:** _____ ***Language:** _____

***Street Address:** _____ **Occupation:** _____

***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	
☐	☐	Actinic keratosis ("precancer")	☐	☐	Lupus erythematosus
☐	☐	Acne	☐	☐	Melanoma: yr ____ site ____
☐	☐	Basal Cell Carcinoma	☐	☐	Psoriasis
☐	☐	Excessive hair growth	☐	☐	Pigmentary problems
☐	☐	Excessive sweating	☐	☐	Rosacea
☐	☐	Eczema	☐	☐	Squamous Cell Carcinoma
☐	☐	Hair loss	☐	☐	Keloid scarring

FAMILY HISTORY

Is there a family history of the following conditions:

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