KING-MACEYKO DERMATOLOGY ASSOCIATES **MR#** **Today's Date:**

Prefix ❑Mr. ❑ Mrs. ❑Miss ❑Ms. ❑Dr. **Preferred Name**:

Patient's Name:

First Middle Last

Address:

Street & Apt # City State Zip

Birthdate Age: Sex: ❑ Female ❑Male

Marital Status: ❑ Single ❑ Married to: ❑ Other:

Home Phone: Work Phone: Ext: Cell Phone:

Preferred Contact: ❑Home ❑ Work ❑Cell ❑Email **E-mail Address:**

Any restrictions for contacting you? ❑No ❑ Yes If yes, please describe

Emergency Contact: Relationship to Patient: Phone#:

Race: ❑African-American ❑Asian ❑ American Indian/Alaska Native ❑Native Hawaiian or Other Pacific Islander ❑White

Ethnicity: ❑Hispanic ❑Non-Hispanic **Preferred Language:**

Referring Dr.: **Primary Care Dr.:**

INSURANCE INFORMATION

Primary Ins.: Insured: Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB:

Secondary Ins.: Insured: Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB:

RESPONSIBLE PARTY

Name: Address:

Relation to Patient: Birth Date:

PHARMACY

Pharmacy: **Phone:** **Street Name/City/St/Zip:**

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Signature:_____ **Date:** _____

In order to establish optial relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. If we file a claim with your insurance you are still responsible for any unmet deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with this policy.

Signature:_____ **Date:** _____

KING-MACEYKO DERMATOLOGY ASSOCIATES, LTD

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have been provided the Practice Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and I have been given the opportunity to read the notice.

_____ _____

(Signature of Patient/Authorized Representative) (Date signed)

_____

(Patient's Name if signed by another person)

If a personal representative is signing the form on behalf of the individual listed, please print the personal representative's name and describe his or her authority to act on behalf of the individual.

_____

(Name of Authorized Representative)

_____

(Authority of authorized representative)

**********FOR OFFICE USE ONLY**********

If unable to obtain the patient's signature in acknowledgement of receipt of the HIPAA Notice of Privacy Practices, document the reason below (emergency etc.)

_____ _____

Patient Name Date

_____

Reason

Patient Name:	MR#:
Appointment Date:	Page 1
Chief Complaint: (Please write reason, symptoms, condition or diagnosis that prompts your appointment)	

Past Medical History

RELEVANT MEDICAL HISTORY		DETAILS
Artificial Joints/Implants	□	
Asthma	□	
Blood Clots/ Bleeding Disorder	□	
Breast Cancer	□	
Chest Pain	□	
Chemical/ Radiation Therapy	□	
Defibrillator	□	
Diabetes	□	
Eye Problems	□	
Heart Disease	□	
Heart Murmur	□	
Hepatitis	□	
High Blood Pressure	□	
Liver Disease	□	
Malignant Hyperthermia	□	
MRSA	□	
Neurologic Disease	□	
Pacemaker	□	
Psychiatric Condition	□	
Radiation Therapy/Chemotherapy	□	
Stroke	□	
Thyroid Disorder	□	
Non-relevant medical history	□	
Other relevant medical history	□	

SKIN HISTORY		Previous Treatments	Location	Notes
None	□			
Acne	□			
Dry Skin	□			
Eczema	□			
Hives or Itching	□			
Infection of the skin	□			
Keratosis	□			
Melanoma	□			
Moles	□			
Psoriasis	□			
Rashes	□			
WHY	□			
Skin Cancer	□			

Patient Name:	MR#:
Appointment Date:	Page 2

SKIN HISTORY (Continued)		Previous Treatments	Location	Notes
Sores – Cold, Bed, etc.	□			
Sun Exposures	□			
Suspicious Lesion	□			
Ulcers	□			
Warts	□			

PAST SURGERIES/HOSPITALIZATIONS

Surgery Type	Surgery/Hospitalization	Year	Anesthesia Complications	Notes

FAMILY HISTORY

		Afflicted Family Member	Notes
Allergies	□		
Autoimmune Disorders	□		
Breast Cancer	□		
BRCA Positive	□		
Diabetes	□		
Heart Disease	□		
High Blood Pressure	□		
Hemophilia	□		
Obesity	□		
Other Cancer	□		
Melanoma	□		
Metabolic Disease	□		
Sinusitis	□		
Skin Cancer Other	□		
Non-relevant family history	□		
Unknown (Adopted)	□		
Other relevant family history	□		
*Females Only	□		
Do you take birth control?	□		
Are you pregnant?	□		
Are you breast feeding?	□		
Do you plan on becoming pregnant?	□		

Preferred Pharmacy Name and Address:	

Patient Name:	MR#:
Appointment Date:	Page 3

SOCIAL HISTORY

Do you live alone?	□ Yes □ No
Do you use recreational drugs?	□ Yes □ No
Have you used a tanning bed?	□ Yes □ No

Do you drink alcohol?	□ Yes □ No		
MEN ONLY	How many times in the past year have you had more than 4 drinks in a day?		
WOMEN ONLY	How many times in the past year have you had more than 3 drinks in a day?		
Smoking Status:	□ Never smoker	□ Current every day smoker	□ Current some days smoker
□ Former smoker	□ Heavy tobacco user	□ Light tobacco user	
□ Unknown if ever smoked	□ Smoker, current status unknown		
Started Date:	Ended Date:		

	YES	
Have you had the flu shot within the last year? (If yes, select an option below)	□	
Influenza immunization previously received at home (home health or pharmacy).	□	Date:
Influenza immunization previously received at work.	□	Date:
Influenza immunization was not administered, reason not given.	□	
If you're 65 or older; have you ever received a pneumonia vaccine? If Yes, date:	□	Date:

Do you take these medications daily?

□ Aspirin □ Advil □ Motrin □ Aleve □ Celebrex □ Coumadin □ Plavix □ Xarelto □ Pradaxa □ Warfarin
□ Any non-listed blood thinner?

Please list any other medications you are taking	**Please list any drug allergies you may have**
MEDICATIONS	**ALLERGIES**

Review of Systems

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

SKIN	YES	NO	Yes - Details
Rash	□	□	
Sores	□	□	
New or changing lesions	□	□	
Itching/burning	□	□	
CONSTITUTIONAL	YES	NO	Yes - Details
Fever	□	□	
Chills	□	□	
Fatigue	□	□	
Weight loss	□	□	