

ORANGE DERMATOLOGY ASSOCIATES, P.C.

PATIENT INFORMATION

(Please Print)

Today's Date ___/___/___

Name _____ SS# _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____
Area Code Area Code Area Code

Date of Birth ___/___/___ Age ___ Sex ___ Marital Status ___ Occupation _____

POLICY HOLDER /RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.

Address _____
City State Zip

Home Phone _____ Work Phone _____ SS# _____
Area Code Area Code

Date of Birth ___/___/___ Sex ___ Marital Status ___ Occupation _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group # _____

Employer Name _____

Employer Address _____

Employer Phone _____
Area Code

Relationship of patient to the Insured _____

Secondary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group# _____

Employer Name _____

Employer Address _____

Employer Phone _____
Area Code

Relationship of patient to the Insured _____

Other family members that are patients _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

WE RESPECT YOUR PRIVACY (The HIPAA Policy is posted in the office)

All medical records of Orange Dermatology Associates, P.C. are strictly confidential. You are entitled to access your own medical records.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to Orange Dermatology Associates, P.C.

I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered, including any unmet deductibles, co-payments and non-covered services. If my account is turned over to a collection agency or if I fail to keep a scheduled appointment, a service charge will be added.

To insure patient confidentiality, our office policy is to give test results to the patient only. If we call your home and another member of your household answers the telephone, may we leave results? Yes No

May we leave personal medical information on your answering machine at home? Yes No

I acknowledge reading this entire page.

Patient or Responsible Party (if minor) Signature _____ Date ___/___/___

Office use only Copy of insurance card (both sides) attached Updated By: _____

MEDICAL HISTORY

Name: _____ DOB: _____ Today's Date: ____/____/____

Current Problem:

1. Reason for visit (*circle*) (rash, growths, skin cancer check, other _____)
2. How long have you had this problem? _____
3. Have you had this problem before? YES NO

 If yes, when? _____ What did you do for it? _____
4. Is this problem worse during certain seasons or with temperature changes? YES NO

 If yes, when? (*circle*) Fall, Winter, Spring, Summer, hot, cold
5. Where is your problem located? (*circle*) Scalp, ears, eyelids, face, neck, chest, back, arms, underarms, hands, fingers, stomach, groin, thighs, legs, feet, toes, hair, nails, mouth
6. Does the problem (*circle*) itch, burn, hurt, bleed, ooze, other? YES NO
7. Has a doctor given you anything in the past to put on or take by mouth for your present skin problem? If yes, please list: YES NO

8. Have you put anything else on the skin yourself? If yes, please list: YES NO

9. Do you have any growths which (*circle*) change color, grow, bleed, hurt, itch? YES NO

 If yes, where? _____

Medications:

10. Are you allergic to any oral or topical medications? If yes, what? YES NO

11. Have you ever had any reaction to dental anesthesia? YES NO
12. List all medications you are currently taking by mouth or putting on your skin (including prescriptions, over-the-counter, vitamins and herbals): _____

Skin:

13. Have you had skin cancer? Type _____ YES NO
14. Have you had (*circle*) psoriasis, eczema, other skin condition? Please list: YES NO

15. Have you had (*circle*) asthma, hay fever? YES NO
16. Do you have problems with healing? If yes, what kind? YES NO
17. Do you develop keloids (thick or elevated scars) after surgery? YES NO
18. Do you bleed easily? YES NO
19. Is there a family history of (*circle*) skin cancer, psoriasis, eczema? YES NO
20. Is there a family history of (*circle*) asthma, hay fever? YES NO
21. Any other family skin condition? If yes, please list _____ YES NO

Social History:

- | | |
|--|---------------------------------------|
| 22. Do you drink alcohol regularly? YES NO
<input type="checkbox"/> <input type="checkbox"/> | 25. What is your Occupation?
_____ |
| 23. Do you smoke cigarettes regularly? YES NO
<input type="checkbox"/> <input type="checkbox"/> | |
| 24. Have you had or been exposed to HIV (AIDS)? YES NO
<input type="checkbox"/> <input type="checkbox"/> | 26. Hobbies?
_____ |

(PLEASE COMPLETE BOTH SIDES)

Systemic:27. Do you have now, or have you ever had diseases or conditions of: *(Please check Yes or No)*

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal:	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis (Inflammation of vein)	<input type="checkbox"/>	<input type="checkbox"/>	<i>(circle)</i> heartburn, acid reflux, ulcers		
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint/Muscle Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Immune Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis. If yes, what type? _____	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer, Type? _____	<input type="checkbox"/>	<input type="checkbox"/>

28. Other diseases or conditions: _____

29. List surgical procedures you have had in the last 6 months: _____

	YES	NO
30. Do you need to take antibiotics by mouth before surgical or dental procedures?	<input type="checkbox"/>	<input type="checkbox"/>
31. a) Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you taking hormones or birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list _____		
32. Were you referred by <i>(circle)</i> physician, friend, relative, other?	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____		

ARE YOU INTERESTED IN GETTING MORE INFORMATION ABOUT COSMETIC PROCEDURES?

a) LASER hair removal?	<input type="checkbox"/>	<input type="checkbox"/>
b) LASER removal of facial redness and spider veins?	<input type="checkbox"/>	<input type="checkbox"/>
c) Microdermabrasion?	<input type="checkbox"/>	<input type="checkbox"/>
d) Sclerotherapy for leg veins?	<input type="checkbox"/>	<input type="checkbox"/>
e) Restylane or Collagen injections	<input type="checkbox"/>	<input type="checkbox"/>
f) Botox Cosmetic	<input type="checkbox"/>	<input type="checkbox"/>

Completed by: Patient _____ Date ____/____/____ Medical Assistant _____ Signed by Patient _____

Reviewed by _____ Date ____/____/____

(HAVE YOU COMPLETED BOTH SIDES?)

ORANGE DERMATOLOGY ASSOCIATES, P.C.

JOSEPH G. TUCHMAN, M.D.

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SAMMY A. HUTMAN, M.D.

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INFORMED CONSENT FOR PROCEDURES

My signature on this form authorizes the Doctors and Physician Assistants of Orange Dermatology Associates, P.C. to perform procedures on me that they feel are necessary for my well being, including, but not limited to injections, freezing with liquid nitrogen (cryosurgery), electrodesiccation, biopsy and excisions. Before any procedure is done, I will be informed, to my satisfaction why the procedure is necessary. I will be told what the procedure involves and what risk there is to my health, if any, if the condition were to remain undiagnosed or untreated.

I understand the risk inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia and the formation of thick or otherwise objectionable scars, and I realize that such, or any, natural complications may result from the surgical procedure.

I give my permission to have any tissue(s) removed during the procedure be sent for histologic examination by a pathologist.

.....
Signature of patient or patient's legal guardian

Date

Signifying informed consent

.....
Witness

Date

Orange Dermatology Associates, P.C.

In an effort to provide our patients with a comfortable and professional experience in our office, Orange Dermatology Associates, P.C. is pleased to offer the option of a chaperone to be with you during your skin examination.

Please indicate below if you would like a chaperone to be with you in the room during the examination along with the doctor and/or physician assistant.

Your preference will remain in effect until you notify us otherwise.

_____ Yes, I would like a chaperone.

_____ No, I do not want a chaperone.

Signature

Date

Print name