

MEDICAL HISTORY

NAME: _____ DOB: _____ Today's Date: ___/___/___

CURRENT PROBLEM (HPI):

1. Reason for visit (**circle**) (rash, growths, skin cancer check, other) _____
2. How long have you had this problem? _____
3. 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 YES NO
4. Does the problem (**circle**) itch, burn, hurt, bleed, ooze, other? _____
5. 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: _____
6. Have you put anything else on the skin yourself? If yes, please list: _____

MEDICATIONS: (Oral or Topical)

- a) Are you currently taking ANY medications by MOUTH (including prescriptions, hormones, birth control pills, over-the-counter supplements, vitamins and herbals) or suppositories, eye drops, ear drops; or putting anything on your skin?
- b) If yes, please list: _____

ALLERGIES: (Oral or Topical medications) Please specify (e.g. rash, hives, itching, etc.)

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

SOCIAL HISTORY:

	YES	NO	UNKNOWN	What is your Occupation?
Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke sometimes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hobbies? _____
Do you still smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink alcohol regularly?	<input type="checkbox"/>	<input type="checkbox"/>		_____
Have you had or been exposed to HIV (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>		

YOUR PERSONAL

PAST OR PRESENT SKIN CONDITIONS: YES NO

Skin cancer Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Other skin condition Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Problems healing	<input type="checkbox"/>	<input type="checkbox"/>
Thick or elevated scars after surgery	<input type="checkbox"/>	<input type="checkbox"/>
Bleed easily	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY: Indicate relationship

(If grandmother or grandfather, INDICATE which one, and ALSO add (m) for maternal or (p) for paternal)

	YES	NO
Skin cancer <input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis <input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>
Eczema <input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma <input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever <input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>
Any other family skin condition? Please list: _____		

(PLEASE COMPLETE BOTH SIDES)

**YOUR PERSONAL
PAST OR PRESENT MEDICAL HISTORY**

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Acid reflux/Ulcers (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, If yes, what type? _____	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis (Vein inflammation)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint/Muscle Disease (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia/Osteoporosis (circle)	<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/Seizures (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis or other Neurologic disorders (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Immune Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Type? _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other diseases or conditions not listed above: _____		
Kidney Disease/Dialysis (circle)	<input type="checkbox"/>	<input type="checkbox"/>			

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

Name/Address/Telephone No. of your **Primary Care Physician** : _____

Name/Address of your **Local Pharmacy**: _____

***FEDERAL GOVERNMENT REQUIREMENT *** RACE _____ ETHNICITY _____ DECLINE

Were you referred by (circle) physician, friend, relative, other? YES NO
Name: _____

FEMALES ONLY YES NO YES NO
Are you pregnant? Are you breastfeeding?

COSMETIC PROCEDURES:

Check if interested in getting more information

- LASER hair removal? "Filler" (Juvederm, Restylane, Radiesse, etc.) injections?
- LASER removal of facial redness and spider veins? BOTOX Cosmetic?
- LASER removal of brown or dark spots?

Completed by: Patient _____ Date ____/____/____
 Medical Assistant _____ Signed by Patient/Parent/Guardian _____ Date ____/____/____
Reviewed by _____

(HAVE YOU COMPLETED BOTH SIDES?)

ORANGE DERMATOLOGY ASSOCIATES, P.C.

PATIENT INFORMATION

(Please Print)

Name Last First M.I. SS#

Date of Birth / / Age Gender Marital Status Occupation

Mailing Address City State Zip

Home # Cell # Work #

Emergency Contact Name/Relationship: Phone #

For Patient Portal Access: Email Address (Are you interested in receiving more information via email about cosmetic procedures and/or promotions? Yes No)

Federal Government Requirement Race Ethnicity Decline

POLICY HOLDER /RESPONSIBLE PARTY (if different from patient)

Name Last First M.I. SS#

Date of Birth / / Gender Marital Status Occupation

Mailing Address City State Zip

Home # Cell # Work #

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

Primary Insurance Name Secondary Insurance Name Name of Insured Insured's ID# Employer Name Relationship to patient

PHARMACY NAME, ADDRESS & PHONE#

PRESCRIPTION PLAN ID NO.

(PLEASE COMPLETE BOTH SIDES)

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

I authorize the release, as necessary, of my medical information, or that of my dependents, to my primary care or referring physicians, or to consultants, or to process insurance claims and prescriptions. I also authorize payment of my medical benefits, whether private or governmental (Medicare), to Orange Dermatology Associates, P.C. for all professional services rendered by their providers to me or my dependents.

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
May we leave personal medical information on your cell phone? Yes No
May we call your cell phone to confirm your appointment? Yes No

I acknowledge reading this entire page including the posted HIPAA privacy notice.

Patient or Responsible Party (if minor)

Signature _____ Date ___/___/___

Print Name _____

ORANGE DERMATOLOGY ASSOCIATES, P.C.

www.orangederm.com

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**BOARD CERTIFIED IN DERMATOLOGY
*CERTIFIED PHYSICIAN ASSISTANT

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 risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, the formation of thick or otherwise objectionable scars, skin color changes, and possible recurrence 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

DATE

PROCEDURE

SIGNATURE

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