

BLUEGRASS DERMATOLOGY AND SKIN SURGERY CENTER, PSC

Registration Patient Information (Please Print)

Date: _____ Chart Number: _____

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ____/____/____ SSN: ____-____-____ Sex: FEMALE MALE Race: _____
(SSN required if under 18 years old)

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Home Address: (Primary) _____

City: _____ State _____ Zip Code _____

Occupation: _____ Employer: _____

Email Address: (List only if you wish to be contacted via email) _____

Person to notify in case of an emergency: _____ Phone: () _____

How did you hear about our practice? Referring Physician Friend Phone Book Other _____

Primary Physician: _____ Phone Number: () _____

Referring Physician: _____ Phone Number: () _____

Bluegrass Dermatology utilizes an automatic electronic system for prescriptions. Please fill in the following info:
Primary Pharmacy Name: _____ Phone Number: () _____
Primary Pharmacy Address: _____ City/State: _____ Zip Code: _____

NAME & DOB OF INSURED: (If Different from the Patient) Name: _____ DOB: ____/____/____
Insurance companies require this information for claim processing. SSN: ____-____-____

PARENT and/or GUARDIAN: (If Patient is under the age of 18):
Last Name: _____ First Name: _____ Middle Name: _____
Home Address: (Primary) _____
City: _____ State: _____ Zip Code: _____
Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
DOB: ____/____/____ SSN: ____-____-____ Sex: FEMALE MALE Employer: _____

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, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan with which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of CASH, CHECK, VISA, MASTERCARD, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing. All balances due that do not get paid within the first 30 days are subject to finances which will accrue interest monthly.

PATIENT or Responsible Party Signature: _____ Date ____/____/____
(PLEASE SIGN HERE)

Patient Name: _____

Chart #: _____

History and Intake Form

Past Medical History: (please circle all that apply) None

AIDS	Breast Cancer	Hepatitis	Lung Cancer
Anxiety	Colon Cancer	Hypertension	Lymphoma
Arthritis	Coronary Artery Disease	HIV	Pacemaker
Artificial joints	Depression	Hypercholesterolemia	Prostate Cancer
Asthma	Diabetes	Hyperthyroidism	Radiation Treatment
Atrial fibrillation	End Stage Renal Disease	Hypothyroidism	Seizures
Bone Marrow Transplantation	Glaucoma	Leukemia	Stroke
	Hearing Loss		

Other _____

Past Surgical History: (please circle all that apply) None

Appendix Removed	Gallbladder Removed	Kidney Stone	Skin Biopsy
Bladder Removed	Heart Valve Replacement	Kidney Transplant	Basal Cell Carcinoma Surgery
Mastectomy	Heart Transplant	Ovarian Cancer	Squamous Cell Carcinoma Surgery
Breast Biopsy	Hysterectomy	Ovarian Cyst	Melanoma Surgery
Breast Reduction	Joint Replacement	Ovaries Removed	Spleen Removed
Breast Implants	Kidney Biopsy	Prostate Biopsy	Testicles Cancer
Colectomy	Kidney Removed	Prostate Removed	Uterine Cancer

Other _____

Skin Disease History: (please circle all that apply) None

Acne	Dry Skin	Itchy Scalp	Precancerous Moles
Actinic Keratoses	Eczema	Keloids	Psoriasis
Asthma	Flaking	Melanoma	Squamous Cell Carcinoma
Basal Cell Carcinoma	Hair loss	Poison Ivy	Warts
Blistering Sunburns	Hay Fever		

Other _____

Patient Name: _____

Chart #: _____

MEDICATION INFORMATION:

I am NOT Currently Taking Any Medication(s) (Check only if applicable)

List all medications you are now taking (include over-the-counter medicines and herbal preparations):
(Please fill in the medication information as completely as possible.)

Medications	Doage(s)	How often taking medication	Prescribed by:

MEDICAL ALLERGY INFORMATION:

(Please fill in completely as possible, only your medical allergy information.)

- ANESTHETIC or LIDOCAINE ALLERGY No Yes
- LATEX ALLERGY and / or BANDAGE ALLERGY (Please circle allergy type) No Yes
- ALLERGIES TO MEDICATIONS No Yes (If you answer Yes, please list medication allergies below)

Medication Allergy	Reaction	Medication Allergy	Reaction

SOCIAL HISTORY: SOCIAL HISTORY: (Check all that apply) NONE

- Alcohol Caffeine Drug user Smoker
- Other: _____

PATIENT or Responsible Party Signature: _____ Date ____/____/____

Patient Name: _____

Chart #: _____

Medical History Questionnaire

Skin / Melanoma Family History Questions:

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No If yes, which relative(s)? _____

Caution Questions: (please circle all that apply)

Have you ever had difficulty stopping bleeding? Yes No

Do you require antibiotics prior to a surgical procedure? Yes No

Have you had an artificial joint replacement? Yes No

If yes, when and what body locations? _____

Do you have an artificial heart valve? Yes No

Do you have a pacemaker? Yes No

Do you have a defibrillator? Yes No

Are you pregnant or currently trying to get pregnant? Yes No

Review of Systems: Are you currently experiencing any of the following?

(Please check yes or no for the following)

Symptom	Yes	No	Symptom	Yes	No
Abdominal Pain			Hay Fever		
Anxiety			Joint Aches		
Bleeding Problems			Muscle Weakness		
Bloody Stool			Neck Stiffness		
Bloody Urine			Night Sweats		
Blurry Vision			Rash		
Changing Mole			Seizures		
Chest Pain			Shortness of Breath		
Cough			Sore Throat		
Depression			Thyroid Problems		
Fever or Chills			Unintentional Weight Loss		
Headaches			Wheezing		

Other _____

PATIENT or Responsible Party Signature: _____

Date ____ / ____ / ____

(PLEASE SIGN HERE)

(Revised 9 / 27 / 2011)