CEDAR DERMATOLOGY

Date: ____________________________

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST MIDDLE INITIAL)	PREFERRED NAME
MAILING ADDRESS (STREET - CITY - STATE - ZIP)	ALTERNATE ADDRESS, IF APPLIES

HOME PHONE	WORK PHONE	CELL PHONE	OTHER

PATIENT BIRTH DATE	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_______________

PATIENT EMPLOYER NAME	EMPLOYER PHONE	
FINANCIALLY RESPONSIBLE PARTY (LAST, FIRST)	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

PRIMARY INSURANCE INFORMATION

INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

INSURED PARTY NAME (LAST, FIRST)	ADDRESS (if different from patient)

HOME PHONE	WORK PHONE	SSN	BIRTH DATE	RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

SECONDARY INSURANCE INFORMATION

INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

INSURED PARTY NAME (LAST, FIRST)	ADDRESS (if different from patient)

HOME PHONE	WORK PHONE	SSN	BIRTH DATE	RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT (Relative or friend not at same address)	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian) **DATE**

CEDAR DERMATOLOGY

Date: ______________________________

PATIENT NAME (LAST, FIRST)	AGE	WEIGHT lbs.	HEIGHT Feet Inches

If you were referred to this clinic by another doctor please list the doctor's name here.

Allergies - Please list any allergies to medications or local anesthetics and list your reaction to them.

____

☐**No Known Allergies**

FAMILY HISTORY – **Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.**

	MOTHER	FATHER	SIBLING (Brother/Sister)
Acne			
Asthma			
Cancer of Skin (Melanoma)			
Cancer of Skin (Non-Melanoma)			
Eczema			
Hay Fever			

SOCIAL HISTORY

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke ☐ Chew

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐ Infrequently ☐ Recovering Alcoholic

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Dependent Child

Occupation: ______________________________ ☐ Retired ☐ Disabled (reason ______________________)

Surgical History: ☐ Joint Replacement ☐ Valve Replacement ☐ Implanted Pacemaker ☐ Implanted Defibrillator

Please list any major surgeries in the last five years.

TYPE OF SURGERY	YEAR	TYPE OF SURGERY (continued)	YEAR

Medical History: Have you ever had any of the following?

☐ NONE of the problems listed
☐ Acne
☐ Asthma
☐ Bleeding Tendencies
☐ Diabetes
☐ Eczema
☐ Hay Fever
☐ Heart Disease
☐ Hepatitis C
☐ HIV
☐ Hives
☐ Pregnant (currently)
☐ Sensitive Skin
☐ Tuberculosis
☐ Other
☐ Skin Cancer - Basal Cell Carcinoma
☐ Skin Cancer – Melanoma
☐ Skin Cancer - Squamous Cell Carcinoma
☐ Skin Cancer – Unknown

Medications: List any and all medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

Authorization to release my health information to someone other than myself:

Name(s)	RELATIONSHIP

DATES OF SERVICE Applies to all dates of service unless otherwise specified FROM: TO:	AUTHORIZATION NEVER EXPIRES UNLESS A DATE IS LISTED BELOW DATE:

All information is authorized unless specified otherwise.

DO NOT RELEASE the following information: ☐ All Records ☐ Charts Notes ☐ Diagnosis ☐ Pathology Reports ☐ Operative Reports

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):