Today's Date ______________________________

Patient's Name (Mr./Mrs./Ms.)________________________________________________________________

Parents (if minor) __________________________________________________________________________

Mailing Address ____________________________________________________________________________

City/State/Zip _____________________________________________________________________________

Primary Phone__________________________ Work/Cell ___________________________Email__________________________

DOB_______________________ Sex__________ DL# _____________________________SS# ____________-_______-__________

Marital Status_______________________________Religion__________________________ Race___________________________

Ethnicity (please circle): Hispanic or Latino Non-Hispanic or Latino Other Unknown Declined

Employer __________________________________________________ Occupation_______________________________________

Primary Care Physician ______________________________________________________________________________________

**Emergency Contact Information:** (Please provide a contact NOT living with you)

Name _________________________________________________Relationship _______________ Phone ______________________

**Responsible Party**

Who is responsible for the account? (Mr./Mrs./Ms.) __________________________________________________________________

Address/City/State/Zip________________________________________________________________________________________

Relationship to patient ____________________________ S S#______________-__________-______________DOB_______________

Employer _______________________________________________________ Occupation ___________________________________

Primary Phone _____________________________ Work/Cell ___________________________Other________________________

**Primary Insurance**

Ins. Co. __________________________________________

Policy # __________________________________________

Group # __________________________________________

Policy Holder _____________________________________

Policy Holder's DOB _______________________________

Relationship to Pt. ________________________________

**Secondary Insurance**

Ins. Co.___________________________________________

Policy #___________________________________________

Group # __________________________________________

Policy Holder______________________________________

Policy Holder's DOB _______________________________

Relationship to Pt.__________________________________

**Financial Policy**

Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances, must be paid at the time of service.

**Authorization and Release (**please sign below)

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits be made to Beaumont Dermatology and Family Practice, LLP. I acknowledge that I am financially responsible for payment of services not covered by insurance.

**Signature:** ____________________________________________________________ **Date:** _________________________________

## Patient Questionnaire

**Name:** ______________________________ **DOB:** ______________**Today's Date:** _____________

PLEASE ***PRINT***

Reason for today's visit: ____________________________________________________________
How long have you had this problem? ____________________________________________________
Previous treatment for above: _________________________________________________________
Please list any Allergies (medication or other): ___________________________________________
List all current medications (prescription and OTC; including Aspirin, vitamins and herbals):
___________________________________________________________________________________
___________________________________________________________________________________
Preferred Pharmacy: ________________________________________________________________
Have you ever had dental anesthesia (Novocain)? YES/NO Were there complications? YES/NO
Do you have now, or have you ever had any of the following conditions:

| | YES | NO |
|---|---|---|
| High blood pressure | | |
| Heart murmur | | |
| Irregular heartbeat | | |
| Vein Inflammation | | |
| Blood clot | | |
| Artificial heart valves | | |
| Pacemaker | | |
| Stents | | |
| Mitral valve prolapse | | |

| | YES | NO |
|---|---|---|
| Diabetes | | |
| Thyroid Disease | | |
| Kidney Disease | | |
| Liver Disease | | |
| HIV/AIDS | | |
| Stroke | | |
| Seizures | | |
| Fainting | | |
| Stomach disorders | | |

| | YES | NO |
|---|---|---|
| Bronchitis | | |
| COPD | | |
| Emphysema | | |
| Asthma | | |
| Seasonal allergies | | |
| Arthritis | | |
| Rheumatoid Arthritis | | |
| Artificial Joint | | |
| Hepatitis | | |

Other: ____________________________________________________________________________

Do you have any form of heart disease which requires that you take antibiotics prior to dental procedures? ______________________________________________________________________

List all surgical procedures and year performed ____________________________________________
___________________________________________________________________________________

**Tobacco use status**: (Please circle one) **Daily** **Occasionally** **Formerly** **Never**

**Alcohol use status:** (Please circle one) **Daily** **Occasionally** **Formerly** **Never**

**Skin:**

Have you had extensive sun exposure? YES/NO Blistering sunburns? YES/NO
Have you ever had skin cancer? YES/NO Do you bleed easily? YES/NO
Do you have a history of skin disease? YES/NO Do you have problems healing? YES/NO
Do you develop keloids (very thick, raised scars) after surgery? YES/NO
Do you develop skin rashes in reaction to medications? ________ Food? _______ Environment? _______
Please list if you have had any other cancers or malignancies: _______________________________

Do you have a family history of any of the following?

Melanoma ________ Family member_______________ Psoriasis ____Family member _______________

Other skin cancer___Family member_______________ Eczema _____Family member _______________

Is there a possibility that you may be pregnant? YES/NO

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient: ____________________ DOB: ______________ SS#: ________________

I understand, on occasion, I may request for Beaumont Dermatology and Family Practice (BDFP) to disclose my protected health information (PHI) with members of my family, a caregiver or a close friend for purposes such as the following:

- To make, change, or cancel an appointment
- To obtain test or lab results on my behalf
- To discuss my current health condition and/or symptoms
- To pick up written prescriptions or pharmaceutical samples on my behalf
- To discuss my billing account
- Other: ______________________________

In such circumstances, the following individuals are authorized to receive my PHI:

- ______________________________
- ______________________________
- ______________________________

The following individuals are specifically **NOT** authorized to receive any of my PHI:

- ______________________________
- ______________________________
- ______________________________

I understand that if information is requested via telephone, the caller may be asked to identify me by providing (a) my social security number and my date of birth as shown on BDFP's records, and (b) the caller's full name shown above. If the request is made in person, the individual may be required to provide proper identification, including a photo ID. I understand that in order to add or delete designated people from this list, I must notify BDFP in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to BDFP.

______________________________

Signature of Patient/Legal Guardian Date

______________________________

Printed Name