Today's Date: ______________________

PATIENT INFORMATION

Name: _______________________________________ Date of Birth: _____/_____/_____ Gender: Male Female

Address: _____________________________________ City: ___________________________ Zip Code: _____________

Primary Phone #: ______________________________ Secondary Phone #: ____________________________________

Employer: _________________________ __________ Occupation: _____________________Work Phone :__________

Social Security #: _____-____-_____ (may be required for insurance) Marital Status: Married Single Divorced Widowed

Email Address:____

PARENT/GUARDIAN OR PERSON RESPONSIBLE FOR PAYMENT

Guarantor Name: _________________________________ Social Security #: _____-____-_____ (may be required for insurance)

Date of Birth: ______/______/______ Relationship to Patient (please check one): ( ) Self ( ) Spouse ( ) Parent

Address: ____ City: ______________________ Zip Code: _______________

Primary Phone #: _________________________________ Secondary Phone #:___________________________________

Employer Name: _________________________________ Work Phone #: ______________________________________

PHARMACY INFORMATION

Pharmacy Name: ____Pharmacy Phone #: _______-_______-_______

EMERGENCY CONTACT

Name: _____________________________________ Relationship: ________________________

Primary Phone #:________________________________ Secondary Phone #: _______________________________

Race: American Indian/Alaskan Native Black/African American White/Caucasian Other: ____________________

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

I hereby consent to a health examination, related diagnostic procedures and treatments provided by Dermatology Center of Northwest Houston. I hereby authorize my insurance company to remit directly to the Dermatology Center of Northwest Houston all payments of benefits otherwise payable to me under the provision of my policy. I request that payment of authorized Medicare benefits be made either me or on my behalf to Dermatology Center of Northwest Houston for any services provided to me. Hereby authorize the release of this information needed to determine benefits payable for related services.

It is the responsibility of the patient to make sure a referral has been obtained. If a referral is not on file by the time of visit, patient is responsible for all services rendered.

Signature: ____ ____Patient ____Parent ____ Legal Guardian

Frontdesk@dermatologynwhouston.com

Name: ____ **Date of Birth**: ____________________

Height: ____**Ft** ____**Inches** **Weight:** __________ **Females Only: Are you pregnant or Breast feeding?** _________

PAST MEDICAL HISTORY: (circle all that apply)

Anxiety	Colon Cancer	Hearing Loss	Lung Cancer
Arthritis	COPD	Hepatitis Type: __________	Pacemaker / Defibrillator
Asthma	Coronary Artery Disease	HIV / AIDS	Prostate Cancer
Atrial Fibrillation	Depression	Hypertension	Radiation Treatment
BPH	Diabetes	Hypercholesterolemia	Seizures
Bone Marrow Transplant	End Stage Renal Disease	Hypothyroid / Hyperthyroid	None/Other:____________
Breast Cancer	GERD	Leukemia	________________________

PAST SURGICAL HISTORY: (circle all that apply)

Appendix Removed	Heart: PTCA	Prostate Removed
Bladder Removed	Heart: Mechanical Valve	TURP
Breast Biopsy	Joint Replacement: _______	Testicle Removed
Breast Mastectomy:	Kidney:	Spleen Removed
___right ___left ___both	Biopsy / Removed / Stones	Uterus Removed
Colectomy:	Kidney Transplant	None / Other: _____________________________________
Colon Cancer Resection	Liver Transplant	Skin Surgery:
Colectomy: IBD	Ovaries Removed:	Melanoma Lymph nodes removed ___Yes ___No
Gallbladder Removed	Cancer/Hysterectomy/Other	Skin Surgery: _____Basal Cell ____Squamous Cell

SKIN MEDICAL HISTORY: (circle all that apply)

Acne	Blistering Sunburns	Melanoma	Squamous Cell
Actinic Keratosis	Dry Skin	Poison Ivy	Other: ____________
Asthma	Eczema	Precancerous Mole	
Basal Cell	Flaking or Skin	Psoriasis	

Do you wear sunscreen? ___Yes ___No ___Daily ___Weekends only SPF: ______________

Do you tan in beds? ___Yes ___No If yes how often: _________

FAMILY HISTORY: (please check if ONLY immediate family members (ex: mom / dad / sisters / brother / children)

Arthritis	Who: __________________	Hypertension	Who: __________________
Breast Cancer	Who: __________________	Lupus	Who: __________________
Cancer type:	Who: __________________	Malignant Melanoma	Who: __________________
Diabetes	Who: __________________	Thyroid Disease	Who: __________________
Heart Disease	Who: __________________	Other	Who: __________________

MEDICATIONS: PLEASE PRINT CLEARLY AND INCLUDE THE DOSE AND FREQUENCY

____

____

Are you allergic to any medications? ___Yes ___No if yes please list:______________________________________

SOCIAL HISTORY:

Do you use tobacco products? ___Yes ___No

Frontdesk@dermatologynwhouston.com

Former smoker? ___Yes ___No

Alcohol Consumption: ___None ___ Seldom ___ Daily

Frontdesk@dermatologynwhouston.com