

If you are under the age of 18 years old, you will need your Parent or Guardian to sign this paperwork.

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Complete Mailing Address \_\_\_\_\_ SS # \_\_\_\_\_ Male/Female \_\_\_\_\_  
(including St., Blvd., Estate, Rd.)  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Married Single Divorced Widowed Partner  
Emergency Contact \_\_\_\_\_

May we leave medical information on your answering machine? Y N

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

May we e-mail personal medical information to you? Y N Email Address \_\_\_\_\_

Alternate Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation/School/Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**Name and Address of person Responsible for the bill:**

Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

**THIS INFORMATION MUST BE COMPLETED**

**INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK IN)**

I, the undersigned, understand that if I fail to provide DCSI with my current non-contracted insurance card within 30 days from the date of service, I will be responsible for the entire balance due. If I fail to provide my contracted insurance card within my plan's timely filing limits, my insurance will not be filed, and an insurance adjustment will not be made.

Primary Insurance Name \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

ID # \_\_\_\_\_

ID # \_\_\_\_\_

Relationship of patient to insured \_\_\_\_\_

Relationship of patient to insured \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

Yes No If yes, please provide their name and phone number below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (\_\_\_\_) \_\_\_\_\_ Phone # (evening): (\_\_\_\_) \_\_\_\_\_

I authorize the release of medical information to my primary care referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.

As a courtesy, DCSI will file claims to all insurance carriers. I understand that it is my responsibility to determine if DCSI is a network provider with my insurance carrier.

I, the undersigned, understand that if my account has not been paid in full within 90 days from the time my insurance responds, the account will be referred to our collection department, The Dermatology Center of Southern Indiana, P.C., for collection procedures and I am responsible for all cost including fees, attorney fees, and court costs.

The staff of this office pledges to give the finest care our capacities allow. Complications are seldom seen in the many surgical procedures performed, however, it should be understood that even small surgical procedures can scar, occasionally bleed, and rarely become infected or incite allergic response.

X \_\_\_\_\_  
Signature Date

# MEDICAL HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you Allergic to any medications? No Yes (Please List) \_\_\_\_\_

Are you allergic to tape or bandaids? No Yes (Please List) \_\_\_\_\_

Are you allergic to any numbing medications or dental anesthesia? No Yes (Please List) \_\_\_\_\_

Please List any other Allergies \_\_\_\_\_

**\*PLEASE HAVE YOUR LIST OF MEDICATIONS AVAILABLE FOR THE NURSE WHEN ASKED**

Do you or have you ever had diseases or conditions of: (please circle)

**Lungs**

- History of Tuberculosis
- Emphysema
- Asthma
- Chronic Cough

**Other Systemic**

- Alzheimer's / Dementia
- Diabetes
- Thyroid
- Kidney
- Bladder
- Stomach
- Bowel
- Hepatitis or Jaundice
- Glaucoma
- Arthritis / Joint Deformity
- Convulsions, Epilepsy or Seizures
- Fainting
- Lupus
- Cancer (what type) \_\_\_\_\_
- Fibromyalgia
- Sexually Transmitted Disease
- Other \_\_\_\_\_

**Vascular**

- High Blood Pressure
- Chest Pain
- Heart Attack
- Heart Murmur
- Heart Valve Prolapse
- Irregular Heartbeat
- Pacemaker / Defibrillator
- Phlebitis
- Bleeding Disorder

**Please answer the following questions:**

Do you drink alcohol?	YES	NO	If YES, drinks per day?
Do you use IV drugs?	YES	NO	If YES, what? How much?
Have you had or have you been exposed to HIV (AIDS)?	YES	NO	
Do you smoke?	YES	NO	If YES, how much?
Are you pregnant?	YES	NO	Due Date:
Do you have artificial joint(s)?	YES	NO	
Do you have a Hearing Aid or impaired hearing?	YES	NO	
Are you required to take antibiotics before minor surgery?	YES	NO	
Have you ever had skin cancer?	YES	NO	Type: Location:
Has anyone in your family had skin cancer?	YES	NO	If YES, who?
Have you had any skin diseases?	YES	NO	
please list: _____			

List type and dates of previous surgeries you have had: \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Signed by Physician \_\_\_\_\_

Date \_\_\_\_\_

**OVER**