PARKS DERMATOLOGY CENTER

MRN_____

Name: _____ **Nick Name:** _____ **Date:**_____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Gender: ❑ **Female** ❑ **Male** ❑ **Other** **DOB:** ____/____/_____ **Birth State:** _____

Race: _____ **Ethnicity:** ❑ **Hispanic** ❑ **Non-Hispanic** ❑ **Other:** _____ ❑ **Decline**

Preferred Language ***(Specify)***_____ **Military Service:** _____ **SS#:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Occupation: _____ **Employer:** _____ **Marital Status:** _____

Do we have your permission to leave a voicemail regarding test results? ❑ **Yes** ❑ **No**

Phone Preference: ❑ **Home Phone** ❑ **Cell Phone**

Is there anyone else we can speak with on your behalf? ❑ **Yes** ❑ **No**

Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

ACTIVE CONDITIONS: Are you CURRENTLY receiving treatment for any condition(s) listed below? Check Y or N

	Y	N		Y	N
Alzheimer's disease	❑	❑	Hepatitis: ***Please check type:*** ☐ ***A*** ☐ ***B*** ☐ ***C***	☐	❑
Anxiety	❑	❑	HIV (Human Immunodeficiency Virus)	❑	❑
Arthritis	❑	❑	High Cholesterol (Hypercholesterolemia)	☐	❑
Asthma	❑	❑	Hyperthyroidism	❑	❑
Atrial Fibrillation	❑	❑	Hypothyroidism	❑	❑
Benign Prostatic Hyperplasia (BPH)	❑	❑	Leukemia	❑	❑
Chronic Obstructive Lung Disease (COPD)	☐	❑	Malignant Lymphoma	❑	❑
Coronary Arteriosclerosis (Coronary Artery Disease)	❑	❑	Malignant tumor of lung (Lung Cancer)	❑	❑
Depressive Disorder	❑	❑	Malignant tumor of Colon (Colon Cancer)	☐	❑
Diabetes Mellitus	❑	❑	Malignant tumor of Colon (Prostate Cancer)	☐	❑
End-Stage Renal Disease (ESRD)	❑	❑	Parkinson's Disease	❑	❑
Epilepsy	❑	❑	Radiation Therapy Treatment	❑	❑
Gastroesophageal Reflux Disease (GERD)	☐	❑	Rheumatoid Arthritis	❑	❑
Hypertension	❑	❑	**Other:** *(pregnant, breast feeding , etc.)*		
Hearing Loss	❑	❑			

PAST SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N

	Y	N		Y	N
Coronary Artery Bypass Graft (CABG)	❑	❑	Hysterectomy	❑	❑
Excision of Basal Cell Carcinoma	❑	❑	Mechanical heart valve replacement	❑	❑
Excision of Malignant Melanoma	❑	❑	Prostatectomy (prostate removed)	❑	❑
Excision of Squamous Cell Carcinoma	❑	❑	Splenectomy (spleen removed)	❑	❑
History of tubal ligation	❑	❑	Total nephrectomy (kidney removed)	❑	❑
History of Appendectomy (appendix removed)	❑	❑	Total Replacement of Knee: (Left, Right, Both)	❑	❑
History of Cholecystectomy (gallbladder removed)	❑	❑	**Transplant History: check all that apply**		
History of Mastectomy: (Left, Right, Both)	☐	❑	❑ Kidney ❑ Heart ❑ Liver ❑ Pancreas		
(Hx) Total Replacement of Hip: (Left, Right, Both)	❑	❑			

SKIN DISEASE HISTORY: Have you ever had any of the following conditions? Check Y or N					
	Y	N		Y	N
Acne	❑	❑	Psoriasis	❑	❑
Actinic Keratosis	❑	❑	Rosacea	❑	❑
Basal Cell Cancer : year/site: _____	❑	❑	Scalp itchy	❑	❑
Dry Skin	❑	❑	Seasonal Allergies	❑	❑
Eczema	❑	❑	Squamous Cell Cancer: year/site: _____	❑	❑
History of Melanoma: year/site: _____	❑	❑	Any immediate family history of melanoma?	❑	❑
Do you wear sunscreen? *What SPF level:*	☐	❑	❑ Mother ❑ Father ❑ Brother ❑ Sister		
Do you tan in a tanning salon?	❑	❑	Other:	❑	❑

SOCIAL AND VACCINATION HISTORY

1. Are you an active tobacco user?
   ❑ Yes ❑ No ❑ Former

2. How many times in the past year have you had 4 or more alcoholic drinks in one day?
   ❑ Never ❑ No alcohol use
   ❑ 1-2 days ❑ 3 or more days

3. Did you have a Pneumonia Vaccination?
   ❑ Yes, *when* _____ (year) ❑ No

4. Did you receive an Influenza (aka "flu") shot?
   ❑ Yes, when _____ (year) ❑ No ❑ Declined

5. Are you allergic to adhesive? ❑ Yes ❑ No

6. Are You allergic to latex? ❑ Yes ❑ No

PLEASE LIST ALL ACTIVE MEDICATIONS BELOW:

Example: aspirin 81 mg 1/day	

PLEASE LIST ANY MEDICATION ALLERGIES: _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Address/ City/Zip: _____

Primary Insurance Carrier: _____ Name of Insured (Subscriber): _____

Subscriber DOB: _____ Subscriber Gender: ❑Male ❑Female Relationship to patient: _____

PAYMENT OF BENEFITS/ AUTHORIZATION OF TREATMENT

Our Practice teaches dermatology residents from Orange Park Medical Center and they may be involved in your care under the supervision of your physician. However, your physician will direct your care and treatment plan during each visit.

I hereby authorize treatment from any licensed medical professional within Parks Dermatology Center, LLC. I understand that this authorization may be used now or in the future. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. We accept VISA, MasterCard, AMEX, DISCOVER and Care Credit for your convenience. Your signature below indicates that you understand and accept this policy. I request the direct payment of all authorized medical benefits to be made to Parks Dermatology Center for any services I received by the physicians or laboratory of Parks Dermatology Center. I authorize any holder of medical information about me to release this information to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred. Parks Dermatology Center, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature: _____ **Date:** _____