DERMATOLOGY PRACTICE OF ROANOKE, P.C.

Account # _____

PLEASE CLEARLY PRINT ALL INFORMATION BELOW

Last Name _____ First Name _____ MI _____

If Minor, in care of (name) _____ Relationship _____

Mailing Address _____

City _____ State _____ Zip Code _____ Sex: Male / Female

DOB _____ Home phone _____ Work phone _____

Soc Sec # _____ Are you married? Y N Are you employed full time? Y N

Employer / School _____

With whom may we speak regarding your personal account and health information?

Name / Relationship: _____ Phone # _____

Name / Relationship: _____ Phone # _____

Primary Care Physician? (Name / practice / phone#) _____

If the patient is a minor, please note that only a parent or legal guardian may accompany them to their visits, and identification will be required

INSURANCE POLICY

If Dermatology Practice of Roanoke is contracted with your insurance company and your visit if for a covered service then we will file a claim for you, and we will collect any copay, coinsurance and / or deductible at the time of service. If we are not contracted with your insurance company or your visit includes non-covered services, you are responsible for payment at the time of service, and as a courtesy we will file a claim for you.

Primary insurance co _____
Insurance ID# _____
Group Name / # _____
Ins. Mailing Address _____
Employer (if group) _____
Policy Holder's Name _____
Policy Holder's Address _____
_____
Policy Holder's DOB _____
Policy Holders Soc Sec # _____

Secondary insurance co _____
Insurance ID# _____
Group Name / # _____
Ins Mailing Address _____
Employer (if group) _____
Policy Holder's Name _____
Policy Holder's Address _____
_____
Policy Holder's DOB _____
Policy Holder's Soc Sec # _____

Chart # _____

DERMATOLOGY PRACTICE OF ROANOKE, P.C.

PLEASE PRINT INFORMATION BELOW

Patient Name: _____ Age: _____ DOB: _____

Are you allergic to any medications ? Yes No If yes, list below:

_____

_____

Please list all medications you are currently taking, or provide a list for us to xerox:

_____

_____

_____

_____

Personal History: (Please circle Y or N)

Thyroid disease	Y / N
Heart disease	Y / N
Pacemaker / defibrillator	Y / N
Irregular heartbeat	Y / N
Artificial heart valve	Y / N
History of clots	Y / N
Lung disease	Y / N
Asthma	Y / N
Diabetes	Y / N
Kidney disease	Y / N
Stomach / bowel disease	Y / N
Hepatitis	Y / N
Arthritis	Y / N
Artificial Joints	Y / N
AIDS / HIV infection	Y / N
Tuberculosis or positive PPD	Y / N
Depression	Y / N
Hearing deficit	Y / N
History of cancer	Y / N

Review of Systems: (Please circle Y or N)

Abdominal pain	Y / N
Joint pains	Y / N
Form exuberant scars / keloids	Y / N
Trouble with wound healing	Y / N
Nail changes	Y / N
Abnormal bleeding	Y / N
Immunosuppression / frequent infections	Y / N
Sore throat	Y / N
Have enlarged lymph nodes	Y / N
Appetite / energy problems	Y / N
Weight changes	Y / N
Diarrhea / bloody stools	Y / N
Sinus symptoms / infections	Y / N
Urinary changes	Y / N
Females only:	
Increased body hair	Y / N
Irregular / heavy periods	Y / N

Skin History –Patient and Family: (Please check all that apply)

Disease	*Patient*	*Parent*	*Sibling*	*Other blood relative*
Melanoma				
Other skin cancers				
Atypical / abnormal moles				
Precancerous lesions				
MRSA				
Eczema				
Psoriasis				
Acne				
Accutane therapy				
Seasonal allergies / rhinitis				
Asthma				

Social History: (Please answer all that apply)

Do you smoke? Yes / No If Yes, how much? _____
Do you drink alcohol? Yes / No If Yes, how much? _____
Do you use IV drugs? Yes / No If Yes, how often? _____
Tanning bed use: Yes _____ No _____ Past _____

Females only: Are you pregnant or planning to become pregnant? Yes / No
Are you breastfeeding? Yes / No
Date of last menstrual period: _____

Completed by: Patient / Representative Name (please print): _____

(Signature): _____ Date: _____

Reviewed: Physician Signature _____ Date: _____