Kevin L. Dawson, MD
Douglas W. Chun, M.D.
Sarah J. Grekin, M.D.
Erin N. Fuller, M.D.

Patient Information (Please print clearly)

Last Name_____First Name & Initials_____ Nickname_____Birth date ____/____/____ Gender: M/F/NB

Home Address _____ City/State_____Zip _____-_____

Marital Status _____ Home Phone _____ Work Phone _____ Cell Phone _____ Preferred #?_____

Is it OK to leave detailed messages on your preferred phone #? Yes No Is it OK to send a text for appointment reminders? Yes No

E-Mail _____ Referred by:_____
For appointment reminders

Do you want to receive e-mails about cosmetic promotional events? Yes No

How did you hear about us? Physician - Friend/Family Member - Phone book - Internet - Other _____

Social Security # _____-_____-_____ Employer_____ Occupation_____

Work Address_____City/State_____Zip_____-_____

Spouse's Name_____Occupation_____Work Phone_____

Emergency Contact _____Relationship_____

Address_____Phone_____

Billing Information (if different from above)

Person responsible

for you account _____SSN _____-_____-_____Phone_____

Address_____ City/State_____Zip _____-_____

Employer_____Address_____Relationship_____

Do you authorize release of your medical information to anyone besides your other doctors and health insurance carrier(s)? **Yes** **No**

If so, whom? (ie. Other Physicians, family) _____

Insurance Information [Do not fill this section out if you have your insurance card(s) today. We can make a copy.]

	Primary	Secondary	Tertiary
Insurance Company:	_____	_____	_____
Group Number:	_____	_____	_____
ID or Policy Number:	_____	_____	_____
Plan/Coverage Code:	_____	_____	_____
Effective Date	_____	_____	_____
Subscriber's Name:	_____	_____	_____
Subscriber's Birth date	_____	_____	_____
Patient's Relationship to Subscriber:	Self / Spouse / Child	Self / Spouse / Child	Self / Spouse / Child
Subscriber's SSN	_____	_____	_____

I authorize Dawson Dermatology to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Champus, private insurance and any other health plan to Dawson Dermatology. This assignment will remain in effect until revoked to me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Dawson Dermatology to release all information necessary to secure payment and treatment.

_____ _____
Patient, Parent or Guardian's Signature Date

Additional Information*

Race (circle one):

Black or African American | White | Asian | American Indian or Alaska Native | Native Hawaiian or Other Pacific Islander | Other

Ethnicity (if Hispainic, American Indian or Alaska Native) _____ Preferred Language _____

If preferred language is not English, do you speak **English (circle one): very well | well | not well | not at all**

If you do not speak English well or do not speak English at all, please bring someone with you that can translate, or have someone available by phone.

***As part of the federal government-directed initiative to insure quality heath care, the Commission to End Health Care Disparities recommends that practices start by collecting self-identified race, ethnicity and language data since these data elements are fundamental building blocks for identifying racial and ethnic health care disparities. Some insurance carriers including Medicare and Medicaid have indicated that they will begin penalizing health care providers that do not maintain this information in your health care record. You have the right to refuse to provide this information, but we would appreciate your cooperation. This information is treated as confidential, like all other information in your health care record.**

Primary Care Physician _____ **Preferred Pharmacy** _____

Medical History

Please list all allergies:

Allergy	Reaction

Please list ALL medications you are currently taking (not just for skin conditions):

Medication Name	Taken for (blood pressure, cholesterol, etc.)

Past Medical History: (please circle all that apply)

Anxiety	Diabetes	HIV/AIDS	Seizures
Arthritis	Kidney Disease	High Cholesterol	Stroke
Asthma	Gastric Ulcers	Lupus	
Heart Disease	Hepatitis	Autoimmune Disease	
Depression	High Blood pressure	Thyroid Problems	NONE

Cancer (list type) _____

Other _____

Past Surgical History:

_____

_____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Precancerous Moles	Melanoma
Actinic Keratoses	Eczema	Psoriasis	
Asthma	Flaking or Itchy Scalp	Basal Cell Skin Cancer	
Blistering Sunburns	Hay Fever/Allergies	Squamous Cell Cancer	NONE

Other _____

Do you wear Sunscreen? Yes No
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Other Family History of Skin Disorders (Only first degree relatives)

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Never Smoked	None
Former Smoker	Less than 1 drink per day
Currently Smoke	1-2 drinks per day
	3 or more drinks per day

ALERTS: (please circle all that apply)

Allergy to Latex	Allergy to topical antibiotics	Defibrillator
Allergy to Adhesive	Artificial heart valve	Pacemaker
Allergy to lidocaine	Artificial joint replacement	Are you breast feeding, pregnant or trying to get pregnant?
Rapid heartbeat with epinephrine	Blood thinners	

Review of Systems: Are you **currently** experiencing any of the following? (Please check yes or no for the following)

Symptom	Yes	No
Recent illness?		
Recent changes in overall health?		
Fever or chills?		
Unexplained fatigue?		
Frequent illnesses?		
Immune suppression (medications or illnesses)?		
Unintentional changes in weight?		
Itchy eyes?		
Nasal congestion/stuffy nose?		
Sore throat?		
New joint pains?		
Changes in your period?		

Other Symptoms: _____

_____

Patient or Guardian Signature _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient: We are required to offer you for review a copy of our Notice of Privacy Practices which state how we may use and/or disclose your health information. Please sign this form to acknowledge review of the Notice.

I acknowledge that I have reviewed and been offered a copy of this office's Notice of Privacy Practices.

PATIENT:_____DATE OF BIRTH:_____
Please print your name here

Signature_____DATE_____

Name and relationship of person signing, if not the patient:

_____DATE_____

For Office Use Only

We have made very effort to obtain written acknowledgement of review of our Notice of Privacy from this patient but it could not be obtained because:

__The patient refused to sign
__Due to an emergency situation it was not possible to obtain an acknowledgement
__We weren't able to communicate with the patient
__Other (please provide specific details)

_____DATE_____
Employee Signature