PATIENT Last_____First_____MI_____Home Phone_____Cell Phone_____

Home Address_____City_____State_____Zip_____

Billing Address_____City_____State_____Zip_____

Date of Birth_____Age_____Sex_____Social Security #_____

Email Address:_____

Employer Name and Address_____Work Phone:_____

Spouse's Name_____Spouse's Employer Name and Address_____
Spouse's Work Phone_____

Emergency Contact: Name_____Phone_____

Pharmacy Preference: _____

Do you have an Advance Directive? Yes or No If yes, would you like to provide our office with a copy? Yes or No

REFERRED TO THIS OFFICE BY:_____ YOUR FAMILY DR:_____

RESPONSIBLE PARTY:
Last_____First_____Address_____Phone_____

Employer's Name and Address:_____Date of Birth:_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or other balance not paid for by your insurance.

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to Dr. Patrick M. Hatfield and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____

DERMATOLOGY MEDICAL HISTORY

Reason for today's visit: _____Date_____

How long have you experienced this condition? _____

What medications (prescription or nonprescription) have you tried to treat this problem? _____

List previous dermatology treatments:_____

Allergies to Medications: _____

List all **medications** you are currently taking (including prescriptions, over the counter meds, vitamins, and herbals): _____

_____

List any other disease or medical conditions: _____

Surgeries: _____**(Women) Are you pregnant?** ___YES ___NO **Week#** _____

What is your occupation? _____ Hobbies? _____

Patient History Forms

Name_____ Date _____

What pharmacy do you use for short term medications? _____

Please fill in the bubbles completely, staying inside the bubble.

Do you have any of the following conditions?

Suspicious moles	O Yes	O No
Suspicious lesions	O Yes	O No
Changing mole	O Yes	O No
Changing lesion	O Yes	O No
Lumps	O Yes	O No

Social History

Do you consume alcohol?	O Yes	O No
If yes, how much per week?	O 1-3 drinks	O 3-6 drinks O 6 or more
Do you smoke?	O Yes	O No
If yes, how much per day?	O less than 1 pack	O 1 pack O more than one pack
Do you use smokeless tobacco?	O Yes	O No

Do you wear a hat and protective clothing when outside?	O Yes	O No
Do you use sunscreen?	O Always	O Sometimes O Never
Have you had at least 1 blistering sunburn?	O Yes	O No
Do you utilize a tanning bed?	O Yes	O No

Which Fitzpatrick skin type do you have? (please choose one)

- O Type I-Very fair skin that always burns and never tans
- O Type II-Fair skin that always burns and sometimes tans
- O Type III-Medium skin that sometimes burns and always tans
- O Type IV-Olive/light brown skin that never burns and always tans
- O Type V-Brown skin that never burns and always tans
- O Type VI-Dark brown or black skin that never burns and always tans

<u>Does anyone in your family have a history of skin cancer?</u>

Mother	O Yes	O No
Father	O Yes	O No
Paternal Grand Father	O Yes	O No
Paternal Grand Mother	O Yes	O No
Maternal Grand Father	O Yes	O No
Maternal Grand Mother	O Yes	O No

Do you have a history of any of the following?

Basal Cell Carcinoma	O Yes	O No
Squamous Cell Carcinoma	O Yes	O No
Melanoma	O Yes	O No
History of keloid / scarring	O Yes	O No
Problems with healing	O Yes	O No
Bruising	O Yes	O No
MRSA (staph infection)	O Yes	O No
Asthma	O Yes	O No
Dizziness	O Yes	O No
Seizures	O Yes	O No
Diabetes	O Yes	O No
Cough	O Yes	O No
Hepatitis A	O Yes	O No
Hepatitis B	O Yes	O No
Hepatitis C	O Yes	O No
AIDS	O Yes	O No
HIV	O Yes	O No
Tuberculosis	O Yes	O No
Blood transfusion	O Yes	O No
Anemia	O Yes	O No
Blood clots	O Yes	O No
Lupus	O Yes	O No

Atrial fibrillation	O Yes	O No
Heart murmur	O Yes	O No
Artificial valves	O Yes	O No
Pacemaker	O Yes	O No
Congestive heart failure	O Yes	O No
Heart stent	O Yes	O No
Irregular heartbeat	O Yes	O No
Emphysema	O Yes	O No
Ventricular fibrillation	O Yes	O No
Heart bypass	O Yes	O No
Bleeding problems	O Yes	O No
High blood pressure	O Yes	O No
Artificial joints	O Yes	O No
Implanted defibrillator	O Yes	O No