

SOUTHWEST SKIN AND CANCER

Date: _____

PLEASE PRINT AND COMPLETE ALL ENTRIES				
PATIENT NAME (LAST, FIRST MIDDLE INITIAL)			PREFERRED NAME	
MAILING ADDRESS (STREET - CITY - STATE - ZIP)			ALTERNATE ADDRESS, IF APPLIES	
HOME PHONE		WORK PHONE		CELL PHONE
E-MAIL				
PATIENT BIRTH DATE	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
PATIENT EMPLOYER NAME		EMPLOYER PHONE		
FINANCIALLY RESPONSIBLE PARTY (LAST, FIRST)		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE

PRIMARY INSURANCE INFORMATION				
INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE
INSURED PARTY NAME (LAST, FIRST)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian

SECONDARY INSURANCE INFORMATION				
INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE
INSURED PARTY NAME (LAST, FIRST)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian

PRIMARY DOCTOR/FAMILY DOCTOR			REFERRING DOCTOR	
IN CASE OF EMERGENCY CONTACT (Relative or friend not at same address)			RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian) _____ DATE _____

SOUTHWEST SKIN AND CANCER

Date: _____

PATIENT NAME (LAST, FIRST)	AGE	WEIGHT lbs.	HEIGHT Feet Inches
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If you were referred to this clinic by another doctor please list the doctor's name here.

Allergies - Please list any allergies to medications or local anesthetics and list your reaction to them.

No Known Allergies

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Acne			
Asthma			
Cancer of Skin (Melanoma)			
Cancer of Skin (Non-Melanoma)			
Eczema			
Hay Fever			

SOCIAL HISTORY

Yes **No** - Do you use tobacco? Smoke Chew

Yes **No** - Do you drink alcohol? Daily Weekly Infrequently Recovering Alcoholic

Marital status: Single Married Divorced Widowed Separated Dependent Child

Occupation: _____ Retired Disabled (reason _____)

Surgical History: Joint Replacement Valve Replacement Implanted Pacemaker Implanted Defibrillator

Please list any major surgeries in the last five years.

TYPE OF SURGERY	YEAR	TYPE OF SURGERY (continued)	YEAR

Medical History: Have you ever had any of the following?

<input type="checkbox"/> NONE of the problems listed	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives	<input type="checkbox"/> Skin Cancer - Basal Cell Carcinoma
<input type="checkbox"/> Acne	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pregnant (currently)	<input type="checkbox"/> Skin Cancer – Melanoma
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Skin Cancer - Squamous Cell Carcinoma
<input type="checkbox"/> Bleeding Tendencies	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Skin Cancer – Unknown
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV	<input type="checkbox"/> Other	

Medications: List any and all medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

Authorization to release my health information to someone other than myself:

Name(s)	RELATIONSHIP
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DATES OF SERVICE Applies to all dates of service unless otherwise specified FROM: TO:	AUTHORIZATION NEVER EXPIRES UNLESS A DATE IS LISTED BELOW DATE:
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All information is authorized unless specified otherwise.
 DO NOT RELEASE the following information: All Records Charts Notes Diagnosis Pathology Reports Operative Reports

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):