CARSON DERMATOLOGY
SKIN CANCER CENTER

Name: ______________________ Today's Date: ______________

Mailing Address: ______________________ City: __________ State: __________

Home Phone: (____) ______________ Work Phone: (____) ______________ SS #: ______________

Date of Birth: ___/___/___ Age: ________ Sex: ________ Marital Status: ______________

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name: ______________________

Mailing Address: ______________________

Home Phone: (____) ______________ Work Phone: (____) ______________ SS #: ______________

Date of Birth: ___/___/___ Sex: ________

INSURANCE INFORMATION *(please present insurance card(s) at time of check in)*

Primary Insurance Name: ______________________

Ins. Address: ______________________

____

Name of Insured: ______________________

Insured's ID #: ______________________

Group #: ______________________

Employer Name: ______________________

Employer Address: ______________________

____

Employer Phone: (____) ______________

Relationship of Patient to the Insured: ______________

Secondary Insurance Name: ______________________

Ins. Address: ______________________

____

Name of Insured: ______________________

Insured's ID #: ______________________

Group #: ______________________

Employer Name: ______________________

Employer Address: ______________________

____

Employer Phone: (____) ______________

Relationship of Patient to the Insured: ______________

Other family members who are patients: ______________________

Pharmacy Choice: ______________________ Phone: ______________

In case of emergency, who should we contact: ______________________ Phone: ______________

Referred by: ______________________

Primary Care Physician: ______________________

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: ______________________ Date: ______________

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services, and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: ______________________ Date: ______________

( ) Copy of insurance card (both sides) attached.

( ) Updated by: ______________________

SURGICAL HISTORY [please list all prior procedures and, if possible, dates]:

____

____

____

Have you ever had any problems/complications related to anesthesia? []yes []no
If yes, please explain____
Is there any family history of problems related to anesthesia? []yes []no
If yes, please explain____

OCULAR HISTORY [please list all problems and/or surgeries]:

____

____

FAMILY HISTORY [please check all that apply]:

[]droopy eyelids	[]heart disease	[]cancer____________
[]diabetes	[]kidney disease	[]other____________

SOCIAL HISTORY:
Do you smoke tobacco? []yes []no Packs per day?__________ How many years?__________
Do you drink alcohol/beer/wine? []yes []no If yes, how much/how often?______________

MEDICATIONS [please list the dosage and frequency]:

____

____

____

____

____

Do you take aspirin, aspirin containing or non-steroidal medications routinely (including Motrin, Advil, Ibuprofen)? []yes []no If yes, which and how often?____________________

ALLERGIES TO MEDICATIONS [please list medication and reaction]:

____

____

____

Are you allergic to [] iodine or shellfish []eggs [] other________________________?

I verify that the preceding information is correct to the best of my knowledge and that I am not withholding information. I understand that if I do not provide all medical information to the doctor, this may alter his ability to provide me with the best plan of medical care.

Signature______________________________ Date______________