Eastside Dermatology – Patient Information
PLEASE PRINT & COMPLETE ALL SECTIONS/SIDES OF THIS FORM

Patient Name_____ **Date of Birth:** _____/_____/_____
(First) (Middle Initial) (Last)

Street Address_____ **Sex:** ❑Male ❑ Female

City_____ State_____ Zip_____

Best Contact Phone Number #1: ( ) _____❑Cell ❑Home ❑Other _____

Best Contact Phone Number #2 ( ) _____❑Cell ❑Home ❑Other _____

SSN#_____-_____-_____ **Race**: _____ **Language**: ❑English ❑Spanish ❑German ❑Other_____

If minor, Parent/Legal Guardian_____ Daytime Phone ( ) _____

Email Address: _____@_____

Family Dr._____ Phone ( ) _____

Referral From: Dr. _____**or** ❑ Ad ❑ Insurance ❑Phone Book ❑Event ❑ Web Search ❑Other

Insurance Information **Copies of all insurance cards must be provided for claims purposes**

Primary: Insurance Company: _____

Policy Holder Name: _____

Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other

Policy Holder SSN: _____-_____-_____

Policy Holder DOB: _____-_____- _____

Secondary: Insurance Company: _____

Policy Holder Name: _____

Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other

Policy Holder SSN: _____-_____-_____

Policy Holder DOB: _____-_____- _____

Parent or Responsible Party (if different from patient): **(person responsible for bills may or may not be policyholder for the insurance)**

Name: _____ Relationship: _____
(First) (Middle Initial) (Last)

Address: _____City:_____State:_____Zip: _____

Best Contact Phone Number #1 :(_____) _____Best Contact Phone Number #2: :(_____)_____

Emergency Contact Information:

Name: _____ Relationship:_____ Phone:(_____)_____

May we leave medical information / test results on your voicemail? ❑ Yes ❑ No

May we discuss medical information / test results with your family members? ❑ Yes ❑ No

If yes, name_____ Relationship_____ Phone :(_____)_____

Patient/Guardian Signature: _____**Date:** _____/_____/_____

Medicare Patients Only:

I request that payment of authorized medical benefits be made either to me on my behalf or to Eastside Dermatology Inc. for any services provided to me by their physicians. I authorize any holder of information about me to release to the Health Care Financing Administration and its agents, any information needed to determine benefits payable to related services.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Please complete other side of form

Patient Health History: In order to treat you safely & effectively, please answer the following questions completely.
This is for our records only; responses are confidential

What problem (s) brings you in today? _____

Medications: (please include both prescription & non-prescriptions) ❑Yes ❑No ❑See Attached if list given to receptionist

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Pharmacy Name: _____ **Telephone #:** (____) _____

Are you allergic to latex? ❑ Yes ❑ No
Are you allergic to any medications? ❑ Yes ❑ No **If Yes**, Please specify: _____

_____

Do you have any of the following? **Please Circle any that apply to you**

Allergic Symptoms	Blood Transfusions	Cold Sores	Recent Mouth Sores
Skin Related Symptoms	Bowel Problems	HIV/AIDS	Seizures
Fever, Headache, Nausea, Dizziness	Breast Feeding	Muscle Pain	Morning Joint Stiffness
Recent Illness	Breathing /Respiratory Difficulties	Joint Pain	Stomach Problems
Ear, Nose, Mouth, Throat Symptoms	Heart/Chest Problems	Keloids/Overgrown Scars	Unexplained Weight Change
Arthritis	Cough	Leg Swelling	Weakness
Asthma	High Blood Pressure/Hypertension	Neurological Symptoms	Diabetes
Back Pain /Injury	Eye or Vision Problems	Pacemaker/Defibrillator	
Bandage Tape Allergy	Glaucoma	Psychiatric/Emotional Difficulties	

Any Other Medical Conditions: _____

_____

Past Medical History / Family History:

Disease	Yourself	Blood Relative	Disease	Yourself	Blood Relative
Eczema	❑	❑	Depression	❑	❑
Diabetes	❑	❑	Psoriasis	❑	❑
Thyroid	❑	❑	Abnormal moles (Dysplastic)	❑	❑

Basal Cell Skin Cancer ❑ ❑ Location: _____ Year: _____

Squamous Cell Skin Cancer ❑ ❑ Location: _____ Year: _____

Malignant Melanoma ❑ ❑ Location: _____ Year: _____

Do you have an artificial heart valve, joint or other prosthesis that requires you to take antiobiotics when you have dental work? ❑ Yes ❑ No If yes, what for? _____

Past Surgery (s) – Do not include routine childbirth, please:

Date	Reason	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? ❑ Yes ❑ No # packs per day? _____ **Do you drink alcohol?** ❑ Yes ❑ No How often? _____

For Women Only: Are you: Pregnant? ❑ Yes ❑ No Trying to become pregnant? ❑ Yes ❑ No
Breast Feeding? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No