PATIENT INFORMATION Date_____

Last Name *First Name* *MI* *Nick Name* *Gender* *DOB* *Age*

Home Address *City* *State* *Zip*

Marital Status *SSN* *Employer* *Occupation*

Primary Care Doctor *Primary Care Phone Number*

Pharmacy *Pharmacy Phone Number* *Pharmacy Address (or City and cross streets)*

CONTACT INFORMATION

Home Phone: _____ Leave voicemail? ☐ Yes ☐ No

Cell Phone: _____ Leave voicemail? ☐ Yes ☐ No

Send text messages? ☐ Yes ☐ No

Email Address: _____

Would you like an invitation to sign up for our **Patient Portal** sent to the above email address? ☐ Yes ☐ No

SURROGATE DECISION MAKER

Do you have someone that can make medical decisions on your behalf if you are unable to? ☐ Yes ☐ No

IF YES, name of surrogate: _____

IF THE PATIENT IS A MINOR, please provide the responsible party information below.
Responsible party is the parent or legal guardian who completes and signs this form.

Last Name *First Name* *DOB* *Relationship to patient*

Home Address *City* *State* *Zip*

*The following provided information will only be used for government reporting purposes.

Race

- ☐ Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Decline

Ethnicity

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Decline

Language

- ☐ English
- ☐ Spanish
- ☐ Indian
- ☐ Russian
- ☐ Decline
- ☐ Other_____

How did you hear about our office? _____

Please list any family members that are patients in our office: _____

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claims and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans, to Johnson County Dermatology for office visits, procedures or hospital charges.

I understand and agree that I am financially responsible for all charges incurred regardless of potential insurance benefits, including but not limited to Co-Payments, Co-Insurance, Deductibles, Pre-Existing and Non-Covered services. I understand that it is my responsibility to verify with my insurance company the physician treating me is covered under my insurance and to get referral(s) and/or authorization(s) for services prior to the service. Further, I understand that services cosmetic or not-medically necessary are not billable to insurance, and I am responsible for paying for those services. Should I have a cosmetic service in addition to medically necessary services during the same visit, I will pay for the cosmetic services, and medically necessary services will be billed to my insurance.

Signature Date

PRIVACY NOTIFICATION

I have read and/or been offered a copy of the Notice of Privacy Practices for Johnson County Dermatology, PA. I understand that I may request a copy of the Privacy Notification in the future by contacting Johnson County Dermatology PA at (913) 764-1125 or by writing to 153 W 151st St, Suite 100, Olathe, KS 66061.

CONSENT FOR RELEASE OF INFORMATION

Who can we speak with about your medical information, care, and/or billing information?

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

If left blank, we will be unable to speak with anyone other than the patient OR parent/legal guardian of a minor patient.

** If you need to make changes to the above preferences, please do so in writing.*

I understand that this acknowledgement will expire 1 year from date signed.

Signature Date

PATIENT HISTORY

This is confidential medical information.
Accurate and complete medical information is needed to help us provide optimal care.

Patient's Name: _____ **Todays Date:**

What is the reason for today's appointment?

_____

MEDICATIONS (list medications you are currently taking, include injectables, herbals and over-the-counter meds):

MEDICATION NAME	DOSAGE	FREQUENCY TAKEN	HOW IT IS TAKEN

MEDICAL HISTORY

Have you ever had skin cancer?

Yes, on record at JCD ☐ No ☐ Unsure

Yes, outside records: _____

List the practitioner that treated it, date it was treated, type of skin cancer, and location on body

Have you previously been diagnosed with any chronic skin conditions?

☐ Psoriasis ☐ Eczema ☐ Other: _____

Have you ever had the following?

☐ AIDS/HIV
☐ Allergies
☐ Arthritis
☐ Asthma
☐ Bleeding disorder or on a blood thinner
☐ Cancer, type: _____
☐ Defibrillator
☐ Depression
☐ Diabetes
☐ Genetic disease, type: _____
☐ GI/bowel disease, type: _____
☐ Glaucoma
☐ Heart attack/disease
☐ Hepatitis, type: _____
☐ High cholesterol / triglycerides
☐ Hypertension
☐ Joint replacement
☐ Lupus
☐ Multiple sclerosis
☐ Organ transplant, type: _____
☐ Pacemaker
☐ Psychiatric disorder
☐ Radiation, explain: _____
☐ Seizures
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis

Other chronic or current medical condition(s) not listed

_____

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM IN ITS ENTIRETY

PATIENT HISTORY

This is confidential medical information.
Accurate and complete medical information is needed to help us provide optimal care.

Patient's Name:

ALLERGIES TO MEDICATIONS

List the medication name and type of reaction

_____ _____

_____ _____

_____ _____

HOSPITALIZATIONS / SURGERIES

List any hospitalizations or surgeries within the last 12 months

_____

_____

_____

OCCUPATION

If retired, please list your former occupation

_____

SUNSCREEN USE

How often do you use sunscreen? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Other sun safe habits? ☐ Hat ☐ UPF rated clothing ☐ Umbrella ☐ Other: __

WOMEN ONLY

Are you currently pregnant? ☐ Yes Due: _____ ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Are you planning pregnancy? ☐ Yes ☐ No

FAMILY HISTORY

	Mother	Father	Siblings	Child
Skin cancer (non-melanoma type)	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Lupus	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐

please notify your clinician or practitioner of any current changes in your health

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM IN ITS ENTIRETY