

Patient Registration

			M F other
First name	Last name	Date of birth	Sex (circle one)
Address		State	Zip
Mobile phone		Home phone	

OK to leave voicemail? Y N _____
Email Address (patient portal access)

Marital status: Single Married Divorced Widowed

	Primary insurance	Secondary insurance	Tertiary insurance
Name of insurance			
Policyholder <small>(if other than patient)</small>			
Policyholder date of birth			
Relationship to patient			

MEDICARE PATIENTS ONLY

Are you employed? Y N End stage renal failure? Y N

Are you disabled? Y N Healthcare proxy? Y N

Living will? Y N

I hereby assign my insurance benefits to be paid to Midwest Dermatology Institute. I authorize the release of information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or the portion not covered by my insurance. I further understand that if there is a dispute regarding my insurance claim, I will be responsible for payment of my account within a reasonable time.

I do acknowledge that Midwest Dermatology Institute has provided the opportunity to review its HIPAA Notice of Privacy Practices and I may request a copy of this document at any time.

Patient/Responsible Party Signature Date

Health History

Do you now have, or have you ever been diagnosed with any of the following conditions? (check if yes)

- Organ transplant
- Defibrillator/pacemaker
- Taking blood thinners
- Require antibiotics before procedures

Female patients:

- Currently pregnant
- Trying to conceive
- Currently breastfeeding

Personal Skin history: Have you ever been diagnosed with skin cancer? Yes No Unsure

If yes, which type?:

- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Melanoma

Family History of skin cancer, non-melanoma?

- Yes No Unsure

Family history of melanoma?

- Yes No Unsure

Other skin conditions:

- Eczema
- Psoriasis
- Actinic Keratosis
- Blistering Sunburns
- Other: _____

Smoking history:

- Non-Smoker
- Current Smoker
- Former Smoker

Pharmacy name and location (scripts are electronically sent)

Current Medications:

Allergies:

Individuals to share your health information

Name	Phone number	Relationship
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Name	Phone number	Relationship
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