Intake and History Form

Name: ______________________________ Date: ______________

Billing Address: ______________________ City / State: ______________________

Street Address: ______________________ City / State: ______________________

Zip Code: ____________ Date of Birth: ______________ Gender: ______________

Phone Number (home): ______________________ Phone Number (cell): ______________________

Email Address: ______________________________

Emergency Contact: ______________________________

Preferred Language: ______________ Race: ______________ Ethnic Group: ______________

Social Security Number ______________________

Preferred Pharmacy

Name: ______________________

Phone Number: ______________________

City or Zip Code: ______________________

If under 18 years of age, please complete:

RESPONSIBLE PARTY : ______________________ DOB : ______________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment to the undersigned physician of any surgical and/or medical benefits, if any, are payable to me for this service.

______________________ X______________________

Signature Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of protected information pertaining to our patients. The purpose of the policy is to ensure that our practice and physicians and staff have the necessary medical information to provide the highest quality medical care possible while protecting the confidentiality of the information of our patients to the highest degree possible. I have been given a copy of the Dermatology Associates & Surgery Center's Privacy Notice and by signing below acknowledge such.

Signature: ______________________ Date: X______________________

I give the physicians and staff at Beckley Dermatology, Inc. my permission to speak with the following person(s) listed below about my medical condition or any other information necessary for treatment or payment operations.

NAME: ______________________ NAME: ______________________

NAME: ______________________ NAME: ______________________

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Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other

Do you wear Sunscreen?

○ Yes ○ No

If yes, what SPF? ________

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Melanoma?

○ Yes ○ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

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Medications	Dose	Route	Frequency

List all current medications:

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy ____________

Quit Smoking:

- mm/dd/yyyy ____________

Number of Packs Per Day: ______

Total Years Smoking: ______

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

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Do you have any advanced directives?

Do Not Resuscitate ____________________

Medical Power of Attorney ____________________

Living Will ____________________

Have you had the following vaccines?

Flu ____________________

PCV 13 (Pneumococcal Conjugate Vaccine) ____________________

PPSV23 (Pneumococcal Polysaccharide Vaccine) ____________________

Occupation and Workplace:

____

____

Any Additional Immediate Family History:

____

____

____

Where did you hear about us?

	Doctors Referral
	Social Media
	Online Ad
	Newspaper
	Mailer
	Word of Mouth
	Other