EAST LOUISVILLE DERMATOLOGY, P.S.C.

(PLEASE PRINT)

Patient's Full Name:_____Preferred Name:_____

Gender Identity: ☐Female ☐Male ☐Transgender Female to Male ☐Transgender Male to Female ☐Genderqueer
☐Choose not to disclose ☐Additional Gender category not listed _____

Date of Birth:_____Age:_____ Social Security Number:_____

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White
☐Hispanic ☐Chose not to disclose ☐Other not listed _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Choose not to disclose

Preferred Language: ☐English ☐Spanish ☐Other not listed_____

Address: _____City:_____State: _____Zip:_____

Email Address: _____

Home Phone: _____Cell #: _____ Marital Status: M S D W

Family Doctor: _____Referring Physician:_____

Employer: _____Work Phone #:_____

Emergency Contact: _____Phone #:_____

Pharmacy Name:_____Phone #:_____

Responsible Party (if different from the patient)

☐ See Attached (Insurance and Prescription cards)

Name: _____Home #: _____Work #:_____

Address: _____City:_____State:_____Zip:_____

Relationship:_____SS#:_____DOB:_____

Policy Holder Information (person who carries the insurance)

Subscriber Name:_____ DOB:_____

Relationship to Patient:_____ SS#:_____

Address:_____City:_____State:_____Zip:_____

ID Number:_____Group Number:_____

Employer:_____Work Phone Number: _____

Assignment of Benefits and Release of Information

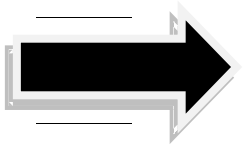
I authorize East Louisville Dermatology to release information necessary to process insurance claims for medical services. I authorize payment of insurance benefits to East Louisville Dermatology for services rendered and agree to pay any charges not covered by my insurance. A service charge may be applied to an outstanding account that has been billed for 90days. I also understand that if my insurance company requires a referral, it is my responsibility to obtain one. If I fail to do so, I will be responsible for any charges incurred. If the patient is a minor, I give my permission for my child to be treated. We reserve the right to charge for appointments missed or canceled with less than 24-hour notice. The charge will be based on the type of appointment scheduled.

Patient's Signature: _____Date : _____

Parent/Guardian Signature: _____Date:_____

☐ Yes, I would like to receive Text Message Reminders.
Phone Number (_____) _____
☐ No, I would not like to receive text message reminders

TURN THIS FORM OVER TO COMPLETE



EAST LOUISVILLE DERMATOLOGY, P.S.C.

_____ _____

GENERAL MEDICAL INFORMATION

Today's skin problem (include location & how long you have had it):_____

_____

Have you seen a provider for this before? Yes / No If Yes, Who? _____
When?_____ What treatment was used? _____
Please List all medications given for this issue: _____

Height:_____ Weight:_____ (required for prescriptions)

Have **you** or anyone in **your immediate family** had the following? If so, please write in their relation to you.

_____Skin Cancer_____Melanoma_____Pre-cancerous or Unusual Moles

Please list ALL medications you currently take (Rx and OTC)

Name of Medication	Dosage	How often Taken

Allergies to medications/food/topicals: _____

Are you allergic to local anesthesia or latex? Yes / No (Lidocaine) (Epinephrine)

Do you require antibiotic pills before dental work? Yes / No

List any surgeries in the past 10 years: _____

Do you currently use tobacco products? Yes / No

Have you had the most current Flu vaccine? Yes / No

Have you had the Covid-19 Vaccine? Yes / No

Have you had the Pneumonia vaccine? Yes / No

Female patients: Are you pregnant? Yes / No Are you breastfeeding? Yes / No

PERSONAL MEDICAL HISTORY

Have you ever had any of the following: (check all that apply)

____Abnormal moles	____Cancer history Type_____	____Kidney Disease	____Heart Attack	____ Other
____Melanoma	____Arthritis	____Diabetes I or II	____Stroke	_____
____Skin Cancer	____Hayfever	____Cataracts	____Ulcers	_____
____Eczema	____Hypertension	____Glaucoma	____Tested Positive for Hepatitis	_____
____Keloids	____Blood Disorder	____Headaches	____Tested Positive for AIDS	