MIDTOWN DERMATOLOGY
PATIENT INFORMATION SHEET

PATIENT INFORMATION:

Last Name: _____ **Preferred Phone:** (____) _____
Home___ Cell___Other___

First Name: _____M.I.____ Secondary Phone: (____) _____
Home___ Cell___Other___

Mailing Address:
_____ **Date of Birth:** _____

City: _____ **State:** _____ **Zip:** _____ **SSN:** _____

EMAIL: _____ Spouse's Name: _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Employed? Yes / No **Employer's Name:** _____

Referred By: _____

INSURANCE INFORMATION:

Primary Insurance Co: _____ Policy Holder's Name: _____
Policy ID Number: _____ Date of Birth: _____
Group Number: _____ SSN: _____
Employer: _____

Secondary Insurance Co: _____ Policy Holder's Name: _____
Policy ID Number: _____ Date of Birth: _____
Group Number: _____ SSN: _____
Employer: _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. **The patient is responsible for all fees, regardless of insurance coverage.** Please **READ** and **SIGN** the following authorization and assignment.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Midtown Dermatology to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

PATIENT'S SIGNATURE: _____ **Today's Date:** _____

A photocopy of the authorization and assignment shall be considered as valid as the original.

MIDTOWN DERMATOLOGY
MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Are you allergic to any medications? Yes / No If yes, Please list:

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Are you currently taking any medications? Yes / No If yes, Please list:

1._____ 3._____ 5._____

2._____ 4._____ 6._____

PAST MEDICAL HISTORY (Please Circle any that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplant
BPH (Benign Prostate Hyperplasia)
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension (High Blood Pressure)
HIV/AIDS
Hyperchloesterolemia (High Cholesterol)
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other_____

PAST SURGICAL HISTORY (Please Circle any that apply)

Appendix
Bladder
Breast: Mastectomy (R/L/Both)
Breast: Lumpectomy (R/L/Both)
Breast: Biopsy
Colon: Colon Cancer Resection
Colon: Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder
Heart: Bypass Surgery
Heart: PTCA (Angioplasty)
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart: Transplant
Joint Replacement: Knee (R/L/Both)
Joint Replacement: Hip (R/L/Both)
Kidney: Biopsy
Kidney: Nephrectomy
Kidney: Kidney Stone Removal
Kidney: Transplant
Liver: Shunt
Liver: Transplant
Liver: Hepatectomy
Ovaries (Oophorectomy): Endometriosis
Ovaries (Oophorectomy): Ovarian Cyst
Ovaries (Oophorectomy): Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas
Prostate: Cancer
Prostate: Biopsy
Prostate: TURP
Rectum: APR
Rectum: Lower Anterior Resection
Skin: Biopsy
Skin: Basal Cell Carcinoma
Skin: Squamous Cell Carcinoma
Skin: Melanoma
Spleen
Testicles
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer
Other_____

SKIN HISTORY (Please Circle any that apply)

Acne
Actinic Keratoses
Basal Cell Carcinoma
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
Other_____

Do you wear sunscreen? Yes / No If yes, what SPF? _____

Do you ***currently*** use a tanning salon? Yes / No Have you ***ever*** used a tanning salon? Yes / No

Do you have a family history of melanoma? Yes / No If yes, what is their relation to you? _____

SOCIAL HISTORY

Smoking Status: Current Smoker Started: _____ Packs per day? _____
Former Smoker Quit:_____
Total years smoked? _____
Never Smoker

Do you exercise? Yes / No If yes, how often? _____

What is your caffeine use? -Several times/day -Once a day -Few times/week
-Few times a month -None -Other_____

Do you drink alcohol? Yes / No If yes, how often? _____

FAMILY HISTORY

Do you have any family history of cancer? Yes / No
If yes, what type and which relative? _____

Do you have any relevant family history you'd like to inform us about? Yes / No

If yes, please specify: _____

Midtown Dermatology

DERMATOLOGY AND DERMATOLOGIC SURGERY
1725 E. 19TH Street, Suite 702
Tulsa, Oklahoma 74104

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

By my signature on the bottom of this page, I acknowledge that I have received a copy of Midtown Dermatology's Notice of Privacy Practices.

Confidential Communication Request

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

Patient Name: _____ **Patient Date Birth:** _____

I, _____ *(print your name)* hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Contact Information:

Home #: _____ ☐ Do ☐ Do not leave messages on my voice mail

Work #: _____ ☐ Do ☐ Do not leave messages on my voicemail
☐ Do ☐ Do not leave messages with any other person

Cell #: _____ ☐ Do ☐ Do not leave messages on my voicemail
☐ Do ☐ Do not send text messages (appt reminders)

Email:_____ (appointment reminders)

Please list other persons that may be contacted with confidential communications if you are unable to be reached:

Name: _____ Relationship to patient: _____ Ph #:_____

Name: _____ Relationship to patient: _____ Ph #:_____

Name: _____ Relationship to patient: _____ Ph #:_____

Signed: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ other (specify) _____