PATIENT DEMOGRAPHIC
(Please Print Legibly)

Patient Name: ____ DOB: ________________________ M / F

Home Phone: ____________________ Work Phone: __________________Cell Phone: ___________________

Mailing Address: _____________________________ City: ______________ State: _____ Zip:______________

Preferred Email: __________________________________Social Security #______________________________

Married: __________ Single: _______ Widowed: _______ Divorced: _______ Legally Separated: ______________

Emergency Contact Name: _______________________________Relationship___________________________

Emergency Contact Phone#: ___________________________

Are you Pregnant? Y / N Planning a Pregnancy? Y / N Are you breastfeeding? Y / N Do you live alone? Y/ N

Primary Care Physician name & Address: ____

Subscriber Name: ____________________________Subscriber Address:________________________________

City: ______________________________________ State: ________ Zip: ______________________________

Subscriber Date of Birth: ___________________ Relationship to Subscriber___________________________

Name and Address of Pharmacy: ____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered including and not limited to Attorney & collection fees . I understand that I am responsible for any and all moneys not paid by my insurance. I will notify you of any changes in the above information. I also understand that it is my responsibility to get a referral from my primary care, if my insurance requires this. I understand that I will be held responsible if my insurance does not pay Agape Dermatology because of a missing referral. I, the undersigned/guardian have read the HIPPA guidelines and understand the training, credentialing, and experience of all practitioners in the clinic.

____

Patient Responsible Party Relationship Date Signed

History and Intake Form

Past Medical History: (**Please check off all that apply**)

- ○ None
- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Atrial Fibrillation
- ○ Bone Marrow Transplant
- ○ BPH
- ○ Breast Cancer
- ○ Colon Cancer
- ○ COPD
- ○ Coronary Artery Disease
- ○ Depression
- ○ Diabetes
- ○ End Stage Renal Disease
- ○ GERD
- ○ Hearing Loss
- ○ Hepatitis
- ○ High Blood Pressure
- ○ HIV/AIDS
- ○ High Cholesterol
- ○ Over Active Thyroid
- ○ Under Active Thyroid
- ○ Leukemia
- ○ Lung Cancer
- ○ Lymphoma
- ○ Prostate Cancer
- ○ Radiation Treatment
- ○ Seizures
- ○ Stroke

Other ____

Past Surgical History: (**Please check off all that apply**)

- ○ None
- ○ Appendix Removed
- ○ Bladder Removed
- ○ Breast Biopsy (Right, Left, Bilateral)
- ○ Lumpectomy (Right, Left, Bilateral)
- ○ Mastectomy (Right, Left, Bilateral)
- ○ Colectomy: Colon Cancer
- ○ Colectomy: Diverticulitis
- ○ Colectomy: IBD
- ○ Colon: Colostomy
- ○ Gallbladder Removed
- ○ Heart Valve Replacement
- ○ Heart Coronary Artery Bypass
- ○ Heart Transplant
- ○ PTCA
- ○ Joint Replacement, Knee (Right, Left, Bilateral)
- ○ Joint Replacement, Hip (Right, Left, Bilateral)
- ○ Kidney Biopsy
- ○ Kidney Stone Removal
- ○ Kidney Transplant
- ○ Kidney Nephrectomy

Kidney Hepactemomy
Liver Transplant
Liver Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian Cyst
Ovaries Tubal Ligation
Pancreatectomy
Prostate Biospy
Prostate Removed: Prostate Cancer
TURP
Rectum APR
Skin Biopsy
Basal Cell Cancer Surgery
Melanoma Surgery
Skin Biopsy
Squamous Cell Cancer Surgery
Spleen Removed
Testicles Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer

Other:____
○

SKIN DISEASE HISTORY: (**Please check off all that apply**)

- ○ None
- ○ Acne
- ○ Actinic Keratosis
- ○ 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

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(s)? ____

MEDICATIONS: (Please list ALL Medications)
____
____
____

ALLERGIES: (Please list ALL Allergies & Reactions)
____
____
____

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Never smoked
Former Smoker

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

OCCUPATION & WORKPLACE: ____

DRIVING STATUS:

Drives in the Daytime Yes No **Drives in Night** Yes No

How often do you exercise ____________________ **What is your caffeine use** ____________________

Medical History: Review of Systems

Do you have a current problem with:

Allergy/Immunologic

↑ **Yes** ↑**No** Premedication prior to procedure
↑ **Yes** ↑**No** Allergy to Adhesive
Yes ↑**No** Allergy to Topical Antibiotic Ointments
↑ **Yes** ↑**No** Allergy to Lidocaine
↑ **Yes** ↑**No** Immunosupression
↑ **Yes** ↑**No** Hay Fever

Integumentary/Skin

↑ **Yes** ↑**No** Rash
↑ **Yes** ↑**No** Changing Mole
↑ **Yes** ↑**No** Problems with Healing
↑ **Yes** ↑**No** Problems with Scarring (Keloid)

Hematology/Lymphatic

↑ **Yes** ↑**No** Blood Thinners
↑ **Yes** ↑**No** Problems with Bleeding

Endocrine

↑ **Yes** ↑**No** Thyroid problems
↑ **Yes** ↑**No** Pregnancy or Planning a Pregnancy

Respiratory

↑ **Yes** ↑**No** Wheezing
↑ **Yes** ↑**No** Shortness of Breath
↑ **Yes** ↑**No** Cough

Neurological

↑ **Yes** ↑**No** Headaches
↑ **Yes** ↑**No** Seizures

Eyes

↑ **Yes** ↑**No** Blurry Vision

Cardiovascular

↑**Yes** ↑**No** Pacemaker
↑**Yes** ↑**No** Defibrillator
↑**Yes** ↑**No** Artificial Joints (past two years)
↑**Yes** ↑**No** Artificial Heart Valve
↑**Yes** ↑**No** Rapid Heart Beat with Epinephrine
↑**Yes** ↑**No** Chest Pain

Gastrointestinal (G.I.)

↑**Yes** ↑**No** Abdominal Pain
↑**Yes** ↑**No** Bloody Stool
↑**Yes** ↑**No** GI Upset with Antibiotics

Musculoskeletal

↑**Yes** ↑**No** Joint Aches
↑**Yes** ↑**No** Muscle Weakness
↑**Yes** ↑**No** Neck Stiffness

Psychiatric

↑**Yes** ↑**No** Depression
↑**Yes** ↑**No** Anxiety

Constitutional/Symptom

↑**Yes** ↑**No** Unintentional Weight Loss
↑**Yes** ↑**No** Fever or Chills
↑**Yes** ↑**No** Night Sweats
Yes ↑**No** Yeast Infections with antibiotics

Genitourinary

Yes ↑**No** Bloody Urine
↑

ENT and Mouth

↑**Yes** ↑**No** Sore Throat

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner (**check all that apply**):

___Home Telephone # ____________________

- OK to leave message with call-back number only
- OK to leave a message with detailed health information

___Work/Cell Telephone # ____________________

- OK to leave message with call-back number only
- OK to leave a message with detailed health information

VERBAL RELEASE OF INFORMATION

Agape Dermatology is allowed to give verbal medical information or updates about your condition to your Power of Attorney or Healthcare/Legal Representative as listed in your medical record. If you wish others, such as relatives or friends, **who ask** about your condition, the right to be verbally informed about your condition when they ask, please list the names of those people on the lines below.

I am authorizing the release of verbal medical information regarding my treatment, care and updates on my condition to the following individuals:

Name: ____Relationship: _________________

Name: ____ Relationship: _________________

Name: ____ Relationship: _________________

- I understand that Agape Dermatology will continue to rely on the information on this form when communicating with others involved in my care unless I request changes.
- I understand that I may revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing and the revocation will not apply to information that has already been disclosed prior to receipt of written revocation.

Patient/Guardian Signature: ____ Date: ___________________

Patient's Printed Name: ____ Date: ___________________

I have received information regarding the providers of care in this organization, a copy of the Patient's Bill of Rights and Responsibilities and information regarding the grievance process. I have been presented with a copy of the notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding health information.

Patient of Responsible Party Signature **Date**