halcyon
DERMATOLOGY

PATIENT INFORMATION **Date:** _____

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Please list your preferred phone numbers where we are authorized to contact you and leave a message:

Phone: 1. (_____)_____ 2. (_____)_____ 3. (_____)_____
Circle one: **HOME/CELL** **CELL/WORK** **CELL/WORK**

Date of Birth:_____ **Sex**: ☐M ☐F **Social Security Number**:_____

Emergency Contact Name:_____Phone:_____ Relationship:_____

Do you have a **POA** (Power of Attorney)? ☐**YES** ☐**NO** Name:_____ Relationship:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated

Patient Race: ☐White ☐Hispanic ☐Asian ☐Black/African American ☐Other:_____

Ethnicity: ☐Hispanic ☐Non-Hispanic **Preferred Language**: ☐English ☐Spanish ☐Other:_____

Employment Status: ☐Full Time ☐Part-Time ☐Self-Employed ☐Retired
Employer Name: _____

Employer Address: _____
Street City State Zip

Primary Care Physician:_____**Telephone**:_____

How did you find us? ☐Yellow Pages ☐Insurance ☐Internet ☐Other _____
☐Physician (Name:_____) ☐Family/Friend (Name:_____)

Insurance Information

Please check one: ☐Self Pay (no insurance) ☐Patient IS the Policy Holder ☐Patient IS NOT the policy holder

If the above named patient is not the primary policy holder, please fill out the following:
SUBSCRIBER/PRIMARY POLICY HOLDER INFORMATION:
Name:_____
Last First M.I.

Date of Birth:_____Social Security Number:_____ Sex: ☐M ☐F

ID Number:_____Group Number:_____

Address:_____
Street City State Zip

Telephone:
(___)_____(___)_____(____)_____
Home Mobile Work ext

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Patient Name:_____ **Signer's Birth Date:**_____
Signer's Address:_____**Signer's Phone:** _____

All Patients - Medication Authority

I understand and give my consent for Halcyon Dermatology to retrieve/review my medication history. I understand this will become part of my medical record. A medication history is a list of medicines that all my healthcare providers have recently prescribed. It is collected from a variety of sources including: a patient's pharmacy, health plans, and other healthcare providers. Without an accurate medication history, providers at Halcyon Dermatology will not be able to safely prescribe any medications for you or perform any procedures.

X Signed:_____ Date:_____

Print Name:_____ Relationship (if not signed by patient): _____

All Patients - Privacy Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

X Signed:_____ Date:_____

Print Name:_____ Relationship (if not signed by patient): _____

All Patients - Financial Policy

I have read and understand the financial policy statement. I agree to make in-full prompt payment when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Halcyon Dermatology under the terms of my policy. This authorization is valid until revoked in writing. The SIGNER must complete THEIR OWN information here (if different from the patient):

X Signed:_____ Date:_____

Print Name:_____ Relationship (if not signed by patient): _____

Medicare Patients Only – Financial Policy

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

X Signed:_____ Date:_____

Print Name:_____ Relationship (if not signed by patient): _____

Please list all persons to whom your protected health information may be disclosed. I authorize release of information to the named persons:

Name:_____ Relationship/Phone_____
Name:_____ Relationship/Phone_____

X Signed:_____ Date:_____

Print Name:_____ Relationship (if not signed by patient): _____

Please list an **email address** where we are authorized to contact you _____
Would you like to receive emails regarding **practice specials**? □yes □no

X Signed:_____ Date:_____

Name:_____Date:_____
Date of Birth:_____ Sex: □M □F Referring Physician:_____
Reason for Visit:_____
Pharmacy Name & Address/Cross streets:_____Pharmacy Phone:_____

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Medical History Form

Medications and Over the Counter meds/supplements:

Name	Dose	Frequency

Allergies: Please list any medication allergies that you have.

_____
_____
_____
_____

Alerts:

If female, are you pregnant, nursing, or think you may be pregnant? □Y □N

If female, are you planning a future pregnancy? □Y □N

Do you have a history of cold sores? □Yes □No

Do you have a pacemaker? □Yes □No

Are you on a blood thinner medication? □Yes □No

Social history

Do you drink alcohol? □Yes □No__

If Yes, #drinks/week_____

Do you use any recreational drugs: □Yes □No__

[Staff note: Enter into MIPS]

Do you smoke? □no □yes, packs per day__

Smoking start date:_____

end date:_____

Occupation: _____

History of Skin Cancer:

□personal history of skin cancer
□personal history of melanoma
□family history of skin cancer

Have you received the following vaccines?:

Covid Vaccine □No □Yes_____(Date)

Pnuemococcal Vaccine (65+ only) □No □Yes_____(Date)
[Staff note: Enter into MIPS]

Flu Vaccine □No □Yes_____(Date)
[Staff note: Enter into MIPS]

Please indicate if you have had any of these conditions.

	Notes
□Basal Cell Carcinoma	
□Squamous Cell Carcinoma	
□Malignant Melanoma	
□Actinic Keratoses	
□Abnormal Moles	
□Other suspicious lesions	
□Other skin condition	

Past Medical History

Asthma/COPD/Emphysema	□Yes □No
Bleeding disorder/blood clot	□Yes □No
Depression	□Yes □No
Diabetes	□Yes □No
Crohn's/ulcerative colitis	□Yes □No
Heart Disease	□Yes □No
Hepatitis	□Yes □No
High blood pressure/ cholesterol	□Yes □No
HIV/AIDS	□Yes □No
Joint replacement/ artificial heart valve	□Yes □No
Stroke	□Yes □No
Seizures/Epilepsy	□Yes □No
Thyroid Disease	□Yes □No
Tuberculosis	□Yes □No

Other

_____
_____

Patient Surgical History: Please list any surgeries and/or hospitalizations including dates:□none

_____
_____
_____

Patient Family History: please list any family history of skin disease, cancers, or other diseases:

_____
_____

Review of Systems

Do you have any of these symptoms?

General	
Weight change	□Yes □No
Fatigue/energy loss	□Yes □No
Fevers	□Yes □No
Heat/cold intolerance	□Yes □No
Night sweats	□Yes □No
Immune	
Frequent infections	□Yes □No
Swollen glands	□Yes □No
Eyes	
Light sensitivity	□Yes □No
Blindness/loss of vision	□Yes □No
Skin	
Rash	□Yes □No
Itching	□Yes □No
Change in hair or nails	□Yes □No
Ear/Nose/Throat	
Sinus Problems	□Yes □No
Trouble swallowing	□Yes □No
Changes in voice	□Yes □No
Digestive	
Abdominal pain	□Yes □No
Heartburn or ulcers	□Yes □No
Loss of appetite	□Yes □No
Nausea or vomiting	□Yes □No
Constipation or Diarrhea	□Yes □No
Heart	
Murmur	□Yes □No
Chest pain	□Yes □No
Irregular heart beat	□Yes □No
Swelling in feet	□Yes □No
Respiratory	
Wheezing	□Yes □No
Shortness of breath	□Yes □No
Bladder	
Frequent urination	□Yes □No
Painful urination	□Yes □No
Bladder leakage	□Yes □No
Reproductive	
Menstrual problems	□Yes □No
Miscarriages	□Yes □No
Hematologic	
Anemia	□Yes □No
Bleed or bruise easily	□Yes □No
Blood clots	□Yes □No
Neurologic	
Headaches/migraines	□Yes □No
Dizziness /Fainting	□Yes □No
Numbness/tingling	□Yes □No
Psychiatric	
Mood changes	□Yes □No
Depression	□Yes □No
Anxiety/nervousness	□Yes □No

Reviewed by MD:_____Date:_____