How did you find us?

- Family/Friend - Name:______________________
- Insurance Provider List:
- Internet Search
- Newspaper Ad
- Physician - Name: ______________
- Yellow Pages
- Other: ______________________

PATIENT INFORMATION

Last Name: ____

First Name:______________________________ MI: ________ Male Female

Preferred Name: ____
("John", "Mr. Jones", etc.)

Patient Date of Birth:____________________ Marital Status: Single Married Divorced Widowed

SS# ______________________________ Legally Separated Partner

Mailing Address: ____

City: ______________________________ State:__________ Zip: ________
(If PO Box, complete Street Address below)

Street Address: ____

City:______________________________ State:__________ Zip: ________
(Complete only if Mailing Address provided above is a PO Box)

Email: ____

Preferred Phone: ______________________ Cell Home Work Other: ________

Alternate Phone: ______________________ Cell Home Work Other: ________

PCP/Family Doctor: ____

Referring Doctor: ____

Do you have an advance directive (Living Will or HealthCare Power of Attorney) regarding your healthcare wishes? Yes No

SEND PATIENT STATEMENTS TO:

Name:______________________________ Relation: ______________________

Address: ____
(If different from patient's)

City:______________________________ State:__________ Zip: ________

INSURANCE INFORMATION SELF PAY

Primary	Secondary
Insurance:______________________	Insurance: ______________________
ID#:______________________	ID#: ______________________
Policy Holder: Patient *(If not patient, complete information below)*	Policy Holder Patient *(If not patient, complete information below)*
Name:______________________	Name: ______________________
DOB:__________ SS#:__________	DOB:__________ SS#: __________
Relation:______________________	Relation: ______________________
Address:______________________	Address: ______________________
City:______________________	City: ______________________
State:__________ Zip:__________	State:__________ Zip: __________

Does your insurance plan require you to have a referral to see a specialist? No Yes I don't know

NOTE: It is the patient's responsibility to get any required referrals.

APEX SKIN
MEDICAL / SURGICAL / AESTHETIC

CONTACT IN CASE OF EMERGENCY:

Name: ____________________

Phone #(s): ____________________ Relationship: ____________________

MEDICAL RELEASE: *Please list any persons to whom your protected health information can be disclosed (e.g., spouse. parent, etc):*

Name: ____________________

Phone #(s): ____________________ Relationship: ____________________

Name: ____________________

Phone #(s): ____________________ Relationship: ____________________

Occupation: ____________________ Employer/Company: ____________________

SPOT CHECK PATIENTS ONLY:

I UNDERSTAND THAT TODAY'S VISIT IS A LIMITED EXAM SPECIFIC TO ONE SPOT OF CONCERN. ____________________
Pt. Initials

NO SHOW AND CANCELLATION POLICY:

We understand that situations arise that may require you to cancel your scheduled appointment. As a courtesy to other patients and our medical staff, we require that you provide our office with a minimum of 24 hours' notice of cancellation.

Patients who fail to keep their scheduled appointment and who do not provide 24-hour notice of cancellation will be considered as NO SHOW. Patients who have two (2) documented NO SHOW appointments will only be able to schedule "SAME DAY" appts for all services with Apex Dermatology providers and staff for a six (6) month period from the date of the last NO SHOW appointment.

SIGNATURE *(Patientor Guardian)* ____________________ **DATE** ____________

COMPLETE PAGE 3 OF THIS FORM FOR MEDICAL HISTORY

APEX SKIN
MEDICAL / SURGICAL / AESTHETIC

MEDICAL HISTORY

Patient:__________ **DOB:** __/__/__ **Reason for visit:**__________ **Appointment Date:** __/__/__

Did a doctor's office send you to us for a specific problem? ☐ Yes ☐ No ☐ If YES, name of referring provider: __________

List any medications, herbal supplements and/or vitamins you are currently taking: ☐ Not taking any medications

__________ __________ __________

__________ __________ __________

Have you had the flu vaccine? ☐ **Yes** ☐ **No** If YES, when? __________

Have you had the pneumonia vaccine? *(patients over 55 years old)* ☐ **Yes** ☐ **No** If YES, when? __________

Do you have or have you had any of the following? *(If yes, please check)* ☐ None

- ☐ Acne
- ☐ Artificial heart valve
- ☐ Artificial joints or metal implant
- ☐ Atopic Dermatitis
- ☐ Atypical moles
- ☐ Autoimmune disease (lupus, rheumatoid arthritis)
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Cold sores/herpes
- ☐ Depression
- ☐ Diabetes
- ☐ Heartburn/Reflux
- ☐ HIV
- ☐ High blood pressure/Hypertension
- ☐ Keloids or scarring problems Kidney
- ☐ disease
- ☐ Liver disease or hepatitis
- ☐ Lung disease
- ☐ Psoriasis
- ☐ Seasonal allergies/asthma
- ☐ Skin Cancer
- ☐ Skin Pre-Cancers (actinic keratoses)
- ☐ Thyroid trouble
- ☐ Ulcers (stomach)
- ☐ Other conditions

Please list: __________

Female patients *(check all that apply)*: I am ☐ pregnant ☐ nursing ☐ planning to become pregnant in the near future

Are you allergic to any medications/anesthetics? ☐ Yes ☐ No
(If yes, please list)

__________ __________ __________

Please list major surgeries/hospitalizations:

__________ Date:______ __________ Date:______

__________ Date:______ __________ Date:______

Please list IMMEDIATE FAMILY that have had any of the following: *(mother, father, maternal or paternal grandmother or grandfather, brother, sister)*

Skin Cancer-Melanoma: __________ Psoriasis: __________

Skin Cancer-Other: __________ Eczema: __________

Other Cancers: __________ Other: __________

Does your insurance require a specific Lab? ☐ Yes ☐ No Name of preferred Laboratory: __________

May we leave a message on your answering machine/voicemail? ☐ Yes ☐ No

Preferred Pharmacy:__________ Phone: __________

Smoking Status:

☐ Never ☐ Former ☐ Current Daily ☐ Current Occasional

Do you use smokeless tobacco? ☐ Yes ☐ No

Drink alcoholic beverages? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you use sunscreen on a daily basis? ☐ Yes ☐ No

Have you traveled outside the U.S. in the past 3 months? ☐ Yes ☐ No

Have you had at least one blistering sunburn? ☐ Yes ☐ No

Have you ever used a tanning bed? ☐ Yes ☐ No

Do you currently use a tanning bed? ☐ Yes ☐ No

Have you RECENTLY had any of the following? *(Please check all that apply)* ☐ None

- ☐ Headache/Fatigue
- ☐ Swollen glands/Rash
- ☐ Fever/chills/wt. change
- ☐ Sun sensitivity
- ☐ Itching
- ☐ Muscle Aches
- ☐ Joint Aches
- ☐ Ringing in ears