APEX SKIN
MEDICAL / SURGICAL / AESTHETIC

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

Insurance: _____

ID#: _____

Policy Holder:
Patient *(If not patient, complete information below)*

Name: _____

DOB: _____ SS#: _____

Relation: _____

Address: _____

City: _____

State: _____ Zip: _____

Secondary

Insurance: _____

ID#: _____

Policy Holder
Patient *(If not patient, complete information below)*

Name: _____

DOB: _____ SS#: _____

Relation: _____

Address: _____

City: _____

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.

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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 not be permitted to schedule any services with Apex Dermatology providers and staff for a full twelve (12) months from the date of the last NO SHOW appointment.

SIGNATURE *(Patient or Guardian)* _____ **DATE** _____

COMPLETE PAGE 3 OF THIS FORM FOR MEDICAL HISTORY

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MEDICAL HISTORY

Patient: _____ **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: _____
- ☐ Skin Cancer-Other: _____
- ☐ Other Cancers: _____
- ☐ Psoriasis: _____
- ☐ Eczema: _____
- ☐ 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

- ☐ Other skin complaints
- ☐ Other systemic complaints
- ☐ Fever/chills/wt. change
- ☐ Sun sensitivity
- ☐ Itching
- ☐ Muscle Aches
- ☐ Joint Aches
- ☐ Ringing in ears