Patient information
Kessel Dermatology

Name: Sex: Marital status:
Street Address: City: State: Zip Code:
Home Phone: Business Phone: Cell Phone:
Social Security Number: Date of Birth: Occupation:
Email Address:
Primary or Referring Doctor's Name: Doctor's Phone Number:
Pharmacy Name: Pharmacy Phone Number:

In Case of Emergency, Who Are We Authorized to Contact

Name: Relation: Phone Number:
Street Address: City: State: Zip Code:

Insurance Information

Insurance Company: Your Relation to Insured:[ ]Self [ ]Spouse [ ]Dependent
Policy Holder's Name (if not self): Policy Holder's Date of Birth:
Policy #: Group #:

Do You Have a Secondary Insurance? [ ]Yes [ ]No. If Yes, Please Complete

Insurance Company: Your Relation to Insured:[ ]Self [ ]Spouse [ ]Dependent
Policy Holder's Name (if not self): Policy Holder's Date of Birth:
Policy #: Group #:

Brief Medical History

1. What are the 1 or 2 main reasons for today's visit (rash, growth, wart, etc)?_____
2. Where is your skin problem?_____ __
3. Is it itchy or painful? _____
4. Have you used any treatment for your skin problem? If yes, please give the names of *everything* used.
   _____
5. How long have you had your skin problem?_____
6. Are you allergic to any medications (Penicillin, sulfur, etc)? If yes, please list:
   _____
7. Please list all pills, medications, or tablets you are presently taking:
   _____
   _____
8. Are you currently pregnant? [ ]Yes [ ]No
9. It is recommended by the American Academy of Dermatology that you have a complete examination of the skin on your first visit. This requires you be appropriately gowned so that we may examine the total skin surface for potentially cancerous growths. Do you wish to have this examination? [ ] Yes [ ] No

MEDICAL HISTORY: Please mark any conditions YOU may have:

[ ]Heart disease	[ ]Stroke	[ ]Cancer – Type_____	[ ]High cholesterol
[ ]Heart Valve Replacement	[ ]Heart Attack	[ ]Diabetes	[ ]Skin cancer
[ ]Pacemaker	[ ]Lupus	[ ]Seizures	[ ]Depression/Anxiety
[ ]Defibrillator	[ ]Artificial Joint-Year_____	[ ]Thyroid disease	[ ]High Blood Pressure
[ ]Heart Failure	[ ]Hepatitis – Type _____	[ ]HIV/Aids	[ ]Other-List below:

_____

I request that payment of authorized benefits be made be made to either me or on my behalf to Kessel Dermatology for any services provided. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.

I verify the accuracy of all the above information including address, phone number, and medical history.

Patient's or Authorized Designee's Signature:_____ Date:_____
Patient's or Authorized Designee's Signature Renewal _____ Date:_____
Patient's or Authorized Designee's Signature Renewal _____ Date: _____
Patient's or Authorized Designee's Signature Renewal _____ Date: _____