Patient Sex: M / F

SOUTHWEST SKIN & CANCER

PATIENT INFORMATION SHEET

PATIENT- Last Name:______________________________First:_________________________MI:__________

Mailing Address:____
Street City State Zip

Phone:__________________________Cell:_________________ Ethnicity: Hispanic or Latino? Yes / No
Race: (circle one) White African-American Asian American-Indian Hawaiian Unknown Other

Social Security#:________________Birth date:_______________E-mail:________________________________

Employer's Name & Phone#:____Student Yes / No
Marital Status: (circle one) Single Married Divorced Separated Widowed Other

Spouse's Name:___________________SSN#_______________Birthdate:______________Work#__________
Insurance Name:________________________________Policy#_________________Group#:________________

RESPONSIBLE PARTY: ___Same as above Last Name:________________First:_______________MI:______
Sex: M / F Birth Date:____________SSN#__________________Drivers Lic#:__________________________
Mailing Address:____City:____________State:_____ZIP:_______
Spouse's Name:______________________________SSN#:___________________Work Phone:____________

PAST DERMATOLOGY HISTORY: (CIRCLE ANY THAT APPLY)

ACNE	SHINGLES	POOR WOUND HEALING	PRE-CANCERS	ROSACEA
GENITAL HERPES	PSORIASIS	ATYPICAL MOLE	COLD SORES	FOLLICULITIS
ECZEMA	HIVES	KELOID/ THICK SCAR		

HISTORY OF MELANOMA YES/NO-IF YES WHERE & WHAT YEAR________________________________
HISTORY OF SKIN CANCER YES/NO-IF YES WHERE & WHAT YEAR______________________________
PAST MEDICAL HISTORY: CANCER / HIV / HEPATITIS / ORGAN TRANSPLANT / DIABETES /
HIGH BLOOD PRESSURE / OTHER____
ALLERGIES TO: TAPE POLYSPORIN LATEX LIDOCAINE BEE STING OTHER:____________
DRUG ALLERGIES:____
CURRENT MEDICATIONS:____
____
PREFERRED PHARMACY:___________________________**HEIGHT**_____________**WEIGHT**_____________

FAMILY HISTORY: (CIRCLE ANY THAT APPLY)

ATYPICAL MOLES	MELANOMA	SKIN CANCER	ASTHMA	
ECZEMA	HAY-FEVER	PSORIASIS	LUPUS	ACNE
ACCUTANE USE	OTHER RELEVANT HISTORY:______________			

ALCOHOL USE: NONE SOCIALLY MODERATE HEAVY CONSUMED IN PAST
TOBACCO USE: NONE 2ND HAND CIGARETTES PIPES CHEWS/DIPS QUIT
ARE YOU PREGNANT/BREAST FEEDING/TRYING TO GET PREGNANT? Yes / No

NOTICE OF PRIVACY POLICY: I understand & have been provided with a *Notice of Privacy Policies* that provides a more complete description of information, uses & disclosures.
I agree that the following individual(s)________________________ Relationship(s)________________________
may have access to my protected health information, including lab or test results, and diagnosis.
________(please initial)

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Southwest Skin & Cancer to release any medical or incidental information that may be necessary for medical reasons or in processing applications for financial benefits, including but not limited to Rehabilitation Services, Social Security, and Workman's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Southwest Skin & Cancer to administer such medications and immunizations and perform such diagnostic/medical/surgical procedures as may be necessary for proper health care. I am aware that any major lab work will be sent to an outside lab and I will receive an additional bill from that facility.
PAYMENT POLICY: All charges for medical care are due and payable at the time service is rendered unless prior payment arrangements have been specifically made. I authorize insurance benefits to be paid directly to Southwest Skin & Cancer. I/We agree to pay all attorneys' fees, court costs, filing fees, including charges or commissions that may be assessed to us by any collections agency retained to pursue this matter, which may be as much as 50% of the principle balance owing. I/We further agree to pay interest at the rate of 1.5% per month (18%per year).

Patient's Signature: **Date:**
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