General Patient Information

Last Name _____ First Name _____ Middle _____ Nickname _____

Date of Birth _____ Age _____ Social Security Number _____ Gender _____ Marital Status _____

Home Phone Number _____ Cell Phone Number _____ Work Phone Number _____

Is it OK to leave a detailed message? Yes Or No

Email Address (optional) _____

Home Address _____ City _____ State _____ Zip _____

Employer's Name _____ Occupation _____

Person to Contact In Case of an Emergency (not living with you) _____ Relationship _____ Emergency Phone No. _____

Preferred Pharmacy _____ City/State _____

Family Physician _____ City/State _____

Referring Physician _____ City/State _____

If Patient Is A Minor Or Dependent

Father's Last Name _____ First Name _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____ Work Phone Number _____

Mother's Last Name _____ First Name _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____ Work Phone Number _____

[ ] Lives with both parents [ ] Lives with mother [ ] Lives with father [ ] Other

Person Responsible For Payment Of Account _____ His/Her SS # _____

I authorize Great Plains Dermatology, PA. to treat my minor patient _____

Signature

Insurance

[ ] Self Paying Patient [ ] Active Insurance

Insurance Company Name _____ Address / City / Zip _____

Policy Holder Last Name _____ First Name _____ Middle _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security Number _____

Policy Holder's Employer _____ Patient Relationship to Policy Holder _____

To Be Completed For All Medicare Patients

- Are you a veteran? [ ] Yes [ ] No
- Did the V.A. refer you here for treatment? [ ] Yes [ ] No
- Do you have a V.A. "fee basis ID card"? [ ] Yes [ ] No
- Do you have a Federal Black Lung Card? [ ] Yes [ ] No
- Is this medical condition due to an accident of any kind? [ ] Yes [ ] No
- If yes, was it: work related?_____ auto related?_____
- Are you covered by any employer's health insurance plan through your own employment or that of a family member? [ ] Yes [ ] No

ONE TIME AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO ME OR ON MY BEHALF TO GREAT PLAINS DERMATOLOGY, P.A. FOR ANY SERVICES FURNISHED ME BY THEIR PHYSICIAN. I AUTHORIZE ANY HOLDER OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient's Signature _____ Date Signed _____

- **I verify all information is correct and to the best of my knowledge.**
- **I hereby authorize Great Plains Dermatology, P.A. to furnish information to insurance carries concerning my illness and treatments.**
- **I understand that claims will be submitted to contracting insurance companies and other electronic carries, and that I am responsible for any amounts not covered by them.**
- **For commerical insurances, I understand that I am responsible for payment of services, either by cash, check, Mastercard, or Visa, on the day of services.**
- **If I am unable to pay the entire amount, I understand that I may request setting up a payment plan PRIOR to seeing the doctor.**
- **Insurance Information will be provided to me so that I may submit claims to my insurance company.**

Patient's Signature _____ Date Signed _____

If you are a new patient please list your reason for seeing the doctor today._____

_____

_____

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Carcinoma
Asthma	Hay Fever / Allergies	None
Basal Cell Carcinoma	Melanoma	
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	

Other _____

Family History:

Do you have a family history of Melanoma? [ ] Yes [ ] No

If yes, which relative(s)? _____

Medications: (please enter all current medications)

_____

_____

_____

Allergies to medications: [ ] Yes [ ] No

(please list)

_____

_____

_____

Latex Allergy: [ ] Yes [ ] No

Social History: (please circle all that apply)

Currently smokes

Has smoked in the past

Has never smoked

Drug Use

Do you wear Sunscreen? [ ] Yes [ ] No

If yes, what SPF?

Do you tan in a tanning salon? [ ] Yes [ ] No

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Hypothyroidism
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal Disease	Lymphoma
BPH	GERD	Pacemaker
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	Hypertension	Seizures
COPD	HIV/AIDS	Stroke
	Hypercholesterolemia	Valve Replacement
	Hyperthyroidism	None

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Carcinoma
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibriods
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None

Other _____