Patient History

Past Medical History
Please circle all that apply:

Anxiety	Coronary Artery Disease	Hypercholesterolemia
Arthritis	Depression	Hyperthyroidism
Asthma	Diabetes	Leukemia
Atrial fibrillation	End Stage Renal Disease	Lung Cancer
Bone Marrow Transplantation	GERD	Lymphoma
BPH	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	Hypertension	Seizures
COPD	HIV / AIDS	Stroke

Other: ____

Past Surgical History
Please circle all that apply:

Appendix (Appendectomy)	Hip Replacement (Right, Left, Both)	Prostatectomy
Bladder (Cystectomy)	Knee Replacement (Right, Left, Both)	Prostate: TURP
Breast Biopsy	Kidney Biopsy	Rectum: APR
Mastectomy (Right, Left, Both)	Kidney Stone Removal	Rectum: Low Anterior Resection
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant	Basal Cell Carcinoma
Breast Biopsy (Right, Left, Bilateral)	Nephrectomy	Melanoma
Colon (Colectomy): Colon Cancer Resection	Liver: Hepatectomy	Skin Biopsy
Colon (Colectomy): Diverticulitis	Liver Transplant	Squamous Cell Carcinoma
Colon (Colectomy): Inflammatory Bowel Disease	Liver: Shunt	Spleen (Splenectomy)
Colon: Colostomy	Ovaries: Endometriosis	Testicles (Orchiectomy)
Gallbladder (Cholecystectomy)	Ovaries: Ovarian Cancer	Uterus: Fibroids Hysterectomy
Biological Valve Replacement (Heart)	Ovaries: Ovarian Cyst	Uterus: Uterine Cancer
Coronary Artery Bypass Surgery	Ovaries: Tubal Ligation	Uterus: Cervical Cancer
Heart Transplant	Pancreatectomy	
Heart: PTCA	Prostate Biopsy	

Other: ____

Family History
Please circle all that apply & list relationship to diagnosed:

Diabetes_____________ Melanoma_____________ Eczema_____________ Psoriasis_____________

Skin History
Please circle all that apply:

Acne	Dry Skin	Poison Ivy	Other: _______________
Actinic Keratoses	Eczema	Precancerous Moles	_____________________
Asthma	Flaking or Itchy Scalp	Psoriasis	_____________________
Basal Cell Skin Cancer	Hay Fever / Allergies	Squamous Cell Skin Cancer	_____________________
Blistering Sunburns	Melanoma		

Do you wear sunscreen? Yes No If yes, what SPF? _______

Do you tan in a tanning salon? Yes No

Social History

Do you smoke? Yes No Have you ever smoke? Yes No When did you quit? _______

Do you use illicit drugs? Yes No Have you ever? Yes No

Do you drink alcohol? Yes No How many do you consume in a day? ___________

Do you drive in the daytime? Yes No Do you drive in the nighttime? Yes No

How often do you exercise? ____________ What is your caffeine use? ____________

Please List All Current Medications or Vitamins including dosage & how often you take them:

____

____

____

Allergies

Please List All Allergies & Reactions:

____

____

____

For patients 65 & older:

Have you had your pneumonia vaccination? ______

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Yes No

Do you have a living will? Yes No

Which statement best reflects your wishes on advanced care recommendations? (Please Check One)

__ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

__ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

__ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Dermatology Associates of Oxford

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Dermatology Associates of Oxford may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology Associates of Oxford's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology Associates of Oxford reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology Associates of Oxford's Privacy Officer at P.O. Box 1158, Oxford, MS 38655.

With my consent, Dermatology Associates of Oxford may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology Associates of Oxford may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Dermatology Associates of Oxford may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dermatology Associates of Oxford restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dermatology Associates of Oxford's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology Associates of Oxford may decline to provide treatment to me.

________________________________ ___________________
Signature of Patient or Legal Guardian Date

____
Print Name of Patient or Legal Guardian

Please list any individuals that we may discuss your health information with:

____

____

Patient Information

Please Print
Name____ **Date**_____/______/_______

Mailing Address: ____
Street/ PO Box City State Zip
Date Of Birth___/____/_____ **Male/Female (Circle one)** **Social Security #**_________________

Email: ____

Telephone: Home__________________ **Cell**__________________ **Work**___________________

Can we text or email you with appointment reminders (Circle one): Yes No

Occupation____________________________ **Employer**________________________________

Address/Phone____

Please Circle One: Single Married Separated Divorced Widowed

Preferred Pharmacy: __________________________ **Initial if we can download your medicines:** _____

Name of Primary Care Physician ____

Name of Referring Physician (if applicable) ____

Responsible Party:
❑Self Only → Skip to Insurance Information ❑Other Guarantor → Complete This Section

Guarantor's Full Name____________________________________ Date of Birth: __/___/__ ___

Social Security #________________Patient Relationship to Guarantor: ❑Child❑Spouse❑Other

Address (if different) ____
Insurance Information:
Primary Insurance Company Name____
Policy #________________________________ Group #________________________

Secondary Insurance Company Name____

Policy #________________________________ Group #________________________

In case of emergency contact:
Name: ______________________________________ Phone: __________________
Relationship: _________________________________ Zip Code: _____________

Insurance Authorization & Assignment:
The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations. I authorize my insurance benefits be paid directly to Dermatology Associates of Oxford, LLC as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage. Also, I understand that I am responsible for all legal fees, attorney fees, collection fees, and any other charges involved in collection of my account should it be in default.

_____________________________ _____________________________ ____/____/______
Responsible Party's Signature Patient's Signature Date