ILLINOIS DERMATOLOGY INSTITUTE

Today's Date: ____/____/____

PATIENT INFORMATION

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

OK to leave message: ☐ Yes ☐ No **OK to leave message: ☐ Yes ☐ No** **OK to leave message: ☐ Yes ☐ No**

Date of Birth: ____/____/____ S.S.N. ____/____/____ Marital Status: _____ Spouse Name: _____

Age: _____ Gender: Born Male ☐ Born Female ☐ If you wish to identify gender identity: _____

Email Address: _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____ S.S.N. ____/____/____ Age: _____ Sex: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: ____/_____/_____ Relationship to patient: _____

☐ HMO (Referral Required) ☐ PPO ☐ Out of Network

Secondary Insurance Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: ____/_____/_____ Relationship to patient: _____

☐ HMO (Referral Required) ☐ PPO ☐ Out of Network

☐ **Self-Pay**

In selecting Self-Pay, you are waiving your right to have your insurance company billed for any non-cosmetic Services.

In case of Emergency, who should be notified? _____ Phone: _____

Can we discuss your medical conditions with other members of your household? ☐ Yes ☐ No Specify: _____

Referred By: ☐ Physician _____ ☐ Family/Friend _____

How did you hear about us? ☐ Family/Friend ☐ Internet ☐ Advertisement ☐ Insurance Referral ☐ Other _____

I authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected. **We accept payment in the form of cash or credit card**. If we do accept a check for payment, and the check does not clear the bank, a $25.00 service fee will automatically be added to your account. **Please note that any procedure performed in the office may be billed separately in addition to the office visit fee**. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/Responsible Party Signature: _____ Date: ____/____/____

Name: _____ Relationship to patient: _____

Please check all the following boxes that apply:

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ BPH (enlarged prostate)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Gastric Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:_____
- ☐ ***No Past Medical Problems***

Past Surgeries

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Breast Reduction
- ☐ Breast: Breast Implants
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Dz
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: PTCA (angioplasty)

Past Surgeries Continued

- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Heart Transplant
- ☐ Joint Replacement: Knee (Right)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Nephrectomy (Kidney Removal)
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Skin: Skin Biopsy
- ☐ Skin: Basal Cell Carcinoma Surgery
- ☐ Skin: Squamous Cell Carcinoma Surgery
- ☐ Skin: Melanoma Surgery
- ☐ Spleen (Splenectomy): Spleen Removal
- ☐ Testicles (Orchidectomy): Testicle Removal
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Other:_____
- ☐ ***No Past Surgical Procedures***

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratoses (precancers)
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ ***No Past Skin Problems***

Skin History

Do you wear sunscreen?

- ☐ Yes. What SPF do you apply?_____
- ☐ No

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Family History

Is there a family history of melanoma?

Mother	☐ Yes ☐ No
Father	☐ Yes ☐ No
Sibling	☐ Yes ☐ No
Grandmother	☐ Yes ☐ No
Grandfather	☐ Yes ☐ No

Medications

With your permission, we can obtain prescription information directly from your pharmacy?

☐ **Yes** ☐ **No (if no, please list all below)**

If yes, please list **non-prescription** medications below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

☐ ***No Current Medications***

Allergies: (Please list all allergies)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

☐ **No Drug Allergies**

Sexual History

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with two or more partners
- ☐ Same gender partner

Drinking Alcohol History

- ☐ No alcohol
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Smoking History

- ☐ Currently smokes daily
- ☐ Currently smokes but not daily
- ☐ Former smoker
- ☐ Has never smoked

Family History of Disease

- ☐ Yes
- ☐ No

Relative and Disease

_____

Relative and Disease

_____

Review of Systems *Have you recently experienced any of the following:*

- ☐ Changing , bleeding or itching mole/lesion
- ☐ Rash
- ☐ Itching
- ☐ Burning Skin
- ☐ Fever/Chills
- ☐ Unintentional Weight Loss
- ☐ Night Sweats
- ☐ Muscle Weakness
- ☐ Joint Aches
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Blurry Vision
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Abdominal Pain/Nausea/Vomiting
- ☐ Bloody Stool
- ☐ Depression
- ☐ Hay Fever
- ☐ Problems Healing
- ☐ Burning with urination
- ☐ Heat or cold intolerance
- ☐ Frequent nose bleeds
- ☐ ***Does not apply***

Alerts

- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Artificial Joint Placed in Last 2 Years
- ☐ Artificial Heart Valve
- ☐ Antibiotic Prophylaxis
- ☐ History of Scarring (Keloid)
- ☐ History of Passing Out (Vasovagal)
- ☐ Organ Transplant Recipient
- ☐ Immunosuppressed (Low Immunity)
- ☐ Allergy to Adhesive
- ☐ Pregnant or Planning a Pregnancy
- ☐ Breast Feeding
- ☐ Stomach Upset with Antibiotics
- ☐ Yeast Infection with Antibiotics
- ☐ Allergy to Topical Antibiotics
- ☐ Anti-coagulated (on blood thinners)
- ☐ Allergic to Lidocaine
- ☐ Rapid Heart Beat with Epinephrine
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ History of MRSA
- ☐ ***Does not apply***

Vaccines

Have you ever had the pneumonia vaccine?

- ☐ Yes
- ☐ No

Female Patients Only

Are you pregnant?

- ☐ Yes Due Date_____
- ☐ No

Are you breast feeding?

- ☐ Yes
- ☐ No

Are you trying to get pregnant?

- ☐ Yes
- ☐ No

Primary Care Physician

_____

Phone_____

Address_____

Prescription Coverage

- ☐ Yes
- ☐ No

Preferred Pharmacy _____

Phone_____

Zip code_____

Preferred Language

- ☐ English
- ☐ Other:_____

Race

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other Race:_____

Ethnic Group

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown