



# Patient Information Form

Today's Date: \_\_\_\_\_

### Patient Information:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name / Suffix: \_\_\_\_\_

Gender: Male / Female

Previous Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)

Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

ZIP: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Mobile Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Primary Language: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Marital Status:    S / M / D / W   

Homebound: Yes / No

**How did you hear about us?:** Phone Book / Internet / Friend /

Insurance Company / Allergy & Derm Web site / Saw Office

**Who Referred You?:** \_\_\_\_\_

### Emergency Contact Information:

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Phone #: \_\_\_\_\_

### Employer Information:

Employer: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

### Guarantor Information:

Same As Patient:    Yes / No *(If no, fill out information below)*

Relationship to you: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)

Address: \_\_\_\_\_

\_\_\_\_\_

ZIP: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Social Security #: \_\_\_\_\_

### Primary Insurance Information:

Insurance Plan Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Patient's relationship to policyholder: \_\_\_\_\_

ID/Certification #: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_

Issue Date: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

### Policy Holder Information:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

### Secondary Insurance Information:

Insurance Plan Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Patient's relationship to policyholder: \_\_\_\_\_

ID/Certification #: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_

Issue Date: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

### Policy Holder Information:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_



# Patient Medical History Form

**Patient Name** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First Middle Initial

**Patient's Primary Doctor** \_\_\_\_\_ **Office Phone # ( )** \_\_\_\_\_  
**Doctor's Office Address** \_\_\_\_\_ **City State Zip** \_\_\_\_\_

**Pharmacy** \_\_\_\_\_ **Phone# ( )** \_\_\_\_\_  
**Pharmacy Address** \_\_\_\_\_ **City State Zip** \_\_\_\_\_

**How long have you lived in Arizona?** \_\_\_\_\_

**Do you have a history of:** Blistering sunburn No / Yes - Tanning bed use No / Yes - Radiation or X-ray treatments No / Yes

**Do you smoke?** No / Yes If yes, how many packs a day \_\_\_\_\_ How long have you smoked? \_\_\_\_\_ years.

**How much alcohol do you consume?** \_\_\_\_\_

**Have you ever had a skin cancer?** NO / YES

If yes, what kind (*circle all that apply*) : **Basal Cell Carcinoma / Squamous Cell Carcinoma / Melanoma**

Where on your body and when?: \_\_\_\_\_

**Is there a family history of skin cancer?** NO / YES If yes, who in your family and what kind of cancer?: \_\_\_\_\_

**Drug allergies:** Have you ever had an allergic reaction to any drug or medication? YES / NO

If yes, please list the drug(s) and type of reaction(s): \_\_\_\_\_

**Have you ever had a latex allergy?** NO / YES

**Have you ever had a tape allergy?** NO / YES

**Do you have any food allergies?** NO / YES If yes, what food(s): \_\_\_\_\_

**Medications:** Please list all prescription and non-prescription medications. Include any over-the-counter drugs, herbs, vitamins, or supplements you are taking or have taken within the past month.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History:** Do you now, or have you ever had, any of the following conditions (*circle all that apply*):

- |                       |                   |                              |                      |                 |
|-----------------------|-------------------|------------------------------|----------------------|-----------------|
| Allergies / Hay Fever | Cancer (not skin) | Faint Easily                 | Infections(frequent) | Post Nasal Drip |
| Anxiety Problems      | Chest Pain        | Headaches                    | Itchy / Burning Eyes | Psoriasis       |
| Arthritis             | Chronic Cough     | Heart Attack / Heart Failure | Keloids              | Runny Nose      |
| Asthma                | Depression        | Hepatitis                    | Liver Disease        | Shingles        |
| Autoimmune Disease    | Diabetes          | High Blood Pressure          | Lupus                | Sinusitis       |
| Bleeding Tendency     | Eczema            | HIV / AIDS                   | Migraines            | Stroke          |
| Bronchitis (chronic)  | Emphysema / COPD  | Hives                        | Pacemaker            | Thyroid Disease |

**What other medical problems do you have?** \_\_\_\_\_

**Do we have your permission to:**

Leave a message on your answering machine at home about your medical condition? NO / YES

Leave a message at your place of employment? NO / YES If yes, phone # ( ) \_\_\_\_\_

Discuss your medical condition with any members of your household? NO / YES

If yes, whom: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Physician Initials:** \_\_\_\_\_