



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:** _____