AFFILIATED TROY DERMATOLOGISTS
4600 Investment Drive Suite 150/260, Troy, MI 48098 - Ph: 248-267-5020 Fax: 248-267-5021

Date_____

Patient_____
Last Name First Name Middle Name

Gender (circle): Male Female Other:_____

Marital Status (circle): Single Married Divorced Widowed Separated

Home
Address_____City_____State_____Zip_____

Date of Birth_____ Age_____ Social Security #_____-_____-_____

Cell Phone_____ Home Phone_____ Work Phone_____

Email Address_____ ☐ Check to add your email to mailing list*
*If you checked the box, please check your email for confirmation instructions. You should receive an email in 24-48 hours.

If Minor, Parent/Guardian Name(s)_____

Parent/Guardian Contact Phone #_____

Person To Contact In Case of Emergency:_____Relation_____

Emergency Contact's Phone #_____

Who referred you to our office?_____

Insurance Information

PRIMARY
Insurance Name:_____

Name of Subscriber:_____

Subscriber's Date of Birth:_____

Subscriber's SSN*:_____
*Please provide only if Insurance uses this # as your ID.

Relationship to Patient:_____

SECONDARY
Insurance Name:_____

Name of Subscriber:_____

Subscriber's Date of Birth:_____

Subscriber's SSN*:_____
*Please provide only if Insurance uses this # as your ID.

Relationship to Patient:_____

Acknowledgement of Receipt of Privacy Notice

By signing below, I hereby acknowledge that I am aware of the Privacy Practices that Affiliated Troy Dermatologists has in place. I can request a copy of this privacy agreement for my records at any time.

Signature_____Date_____
(Patient/Guardian)

Authorized Persons Allowed to Receive Confidential Information

Patient's Name_____ Date of Birth_____

If Minor, Name of Parent(s)/Guardian(s)_____

I,_____, patient or patient's parent/guardian authorize Affiliated Troy Dermatologists to give personal information to the following people in the event that they call and have questions regarding medical condition(s):

	Name	Phone #
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

☐ **I do not wish to list anyone to receive medical information at this time.**

I have read and understand the above and allow Affiliated Troy Dermatologists to give personal information to the above listed persons.

_____

Signature of Patient/Guardian **Date**

Assignment of Benefits

Patient's Name_____ Date of Birth_____

As the patient or parent/guardian of the patient, I agree to the following:

The use of this form on all insurance submissions.

The release of information to my/the patient's insurance companies.

The responsibility for my/the patient's bill.

The doctor may act as my/the patient's agent in helping to obtain payment from the insurance companies.

A copy of this authorization to be used in place of the original.

The doctor may file a complaint to the insurance commissioner on my behalf.

The doctor may notify the insurance companies, when their policy prohibits payment to the physician directly, to mail the checks made out to me to their office address.

Regardless of the divorce decree whoever brings in the minor is responsible for payment.

I have read and understand all of the above statements and agree with their provisions.

Signature of Patient/Guardian **Date**

DATE: _____ PATIENT NAME: _____ D.O.B:_____ SEX: MALE / FEMALE

Marital Status (Circle One): Single – Married – Divorced – Widowed Preferred Language:_____

Race:_____Ethnic Group: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ Unknown ☐ I choose not to specify

Pharmacy:_____ Pharmacy Phone Number: _____

Primary Care Physician: First Name_____Last Name: _____

Past Medical History: (please circle all that apply)		
Anxiety Arthritis Asthma Atrial fibrillation BPH Bone Marrow Transplantation Breast Cancer Colon Cancer COPD Coronary Artery Disease	Depression Diabetes End Stage Renal Disease GERD Hearing Loss Hepatitis Hypertension HIV/AIDS Hypercholesterolemia Hyperthyroidism Hypothyroidism	Leukemia Lung Cancer Lymphoma Prostate Cancer Radiation Treatment Seizures Stroke Valve Replacement None
Other _____		
Past surgical history: (please circle all that apply)		
Appendix removed Bladder removed Mastectomy (right, left, bilateral) Lumpectomy (right, left, bilateral) Breast biopsy (right, left, bilateral) Breast reduction Breast implants Colectomy Gallbladder removed Coronary artery bypass	Angioplasty (PTCA) Mechanical valve replacement Biological valve replacement Heart transplant Joint replacement:_____ Joint replacement within last 2 years Kidney biopsy Kidney removed (right, left) Kidney stone removal Kidney transplant	Ovaries removed: _____ Prostate removed: prostate cancer Prostate biopsy TURP Skin biopsy Spleen removed Testicles removed (right, left, bilateral) Hysterectomy: _____ None
Other _____		
Skin disease history: (circle all that apply)		
Acne	Eczema	Psoriasis
Actinic keratoses	Flaking or itchy scalp	Squamous cell skin cancer
Basal cell skin cancer	Melanoma	None
Blistering sunburns	Poison ivy	
Dry skin	Precancerous moles	
Other		

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? IF YES, WHICH RELATIVE(S)?:_____

DO YOU WEAR SUNSCREEN?: ☐**YES** ☐**NO** **IF YES, WHAT SPF?: _____**

DO YOU TAN IN A TANNING SALON?: ☐**YES** ☐**NO** IF NO, HAVE YOU IN THE PAST? ☐**YES** ☐**NO**

MEDICATIONS: _____
☐No Medications

MEDICATION ALLERGIES:_____
☐No Known Drug Allergies

SOCIAL HISTORY (SMOKING): ☐ NEVER SMOKED ☐ FORMER SMOKER ☐ CURRENT SOMETIMES SMOKER ☐CURRENT EVERYDAY SMOKER

DO YOU HAVE A FAMILY HISTORY OF (CIRCLE ALL THAT APPLY): ☐**NONE**

	NON-MELANOMA SKIN CANCER	PSORIASIS	ECZEMA	SEASONAL ALLERGIES	ASTHMA	AUTOIMMUNE DISEASE (I.E. LUPUS)
WHICH RELATIVE(S):						

REVIEW OF SYSTEMS: CIRCLE ALL THAT APPLY		**ALERTS**
Constitutional: Chills Fever Headaches Unintentional weight loss **Respiratory:** Asthma Chronic cough Shortness of breath	**Ears, nose, throa**t: Sore throat Sinus problems Ear aches **Endocrine**: Thyroid disorder **Allergic/immunologic:** Hay fever Immunosupression	Allergic to Latex Allergic to Lidocaine Premedication Prior to Procedures Pacemaker Pregnancy or Planning a Pregnancy
Psychiatric: Mood swings Memory loss Anxiety Depression **Musculoskelatal:** Pain in joints Ankle swelling Difficulty with muscle strength Neck stiffness **Neurological:** Seizures	**Hematologic / Lymphatic** Problems with bleeding **Skin**: Hair loss New skin lesions Change in moles Rashes Skin ulcers Nail changes Problems with healing Problems with scarring	Rapid Heartbeat with Epinephrine MRSA Defibrillator Blood Thinners Artificial Joints within the past two years Artificial Heart Valve
Cardiovascular: High blood pressure Chest pain Irregular heart beat Other heart disease	**Gastrointestinal:** Nausea/vomiting Bowel changes Abdominal pain Bloody stool	Allergic to topical antibiotic ointments Allergic to Adhesives
Eye: Visual problems	**Genitourinary:** Bloody urine	

REASON FOR TODAY'S VISIT: _____