

Jones Dermatology

Patient Information

Patient's Last Name:		First Name:		Middle Initial:	
Mailing Address:			City:	State:	Zip:
Social Security #				Date of Birth:	
Street Address, City, State, Zip (if different than mailing):					
Email Address:					
Home Phone: ()		Cell Phone: ()		Work Phone: ()	
Primary Care Physician:			Referring Provider:		
How Did You Hear About Our Office? <input type="checkbox"/> Internet: <input type="checkbox"/> Physician (same as above) <input type="checkbox"/> Friend/Relative: <input type="checkbox"/> Other:					

RESPONSIBLE PARTY (If patient is a child)

Last Name:		First Name:			
Mailing Address		City:		State	Zip
DOB:	Relationship to Patient:		Best # to reach by phone: ()		
Social Security #:					

PRIMARY INSURANCE (please give your insurance card to the receptionist)

<input type="checkbox"/> Self-Pay <input type="checkbox"/> Patient is the Insured Subscriber	Policy Subscriber's Name (if not patient):		Policy Subscribers DOB:		
Name of Primary Insurance:		Policy Subscriber's Social Security #:			
Patient's Relation to Card Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child					
If Medicare Patient, are you currently employed: <input type="checkbox"/> Y <input type="checkbox"/> N					

SECONDARY INSURANCE (please give your insurance card to the receptionist)

<input type="checkbox"/> Self-Pay <input type="checkbox"/> Patient is the Insured Subscriber	Policy Subscriber's Name (if not patient)		Policy Subscribers DOB: (if not patient)		
Policy Subscriber's Social Security:					

IN CASE OF EMERGENCY

Name of Emergency Contact Person:		Relation to Patient:	Home Phone: ()	Cell Phone: ()
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Co-pays and deductibles will be collected at the time of service. Payment for cosmetic procedures and products are due at the time of service. I authorize Dr. Jones and Dr. Matherne to evaluate and treat my medical condition. I authorize the release of medical information as needed to my primary care physician, referring physician, consultants and insurance carrier to process insurance claims, applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient/Guardian Signature			Date:		
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Medical History

Name: _____ Date: _____

Reason for Visit: _____

Do you have or have you had any of the following:

<p><u>GENERAL</u></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Hair loss <input type="checkbox"/> Headache <input type="checkbox"/> Weight change	<input type="checkbox"/> Keloid/scarring problems <input type="checkbox"/> Melanoma <input type="checkbox"/> Mole change <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sore that won't heal	<p><u>CARDIOVASCULAR</u></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High Blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Swelling of ankles	<p>MEN only</p> <input type="checkbox"/> Sore on genital <input type="checkbox"/> Other _____
<p><u>SKIN</u></p> <input type="checkbox"/> Acne <input type="checkbox"/> Actinic Keratosis <input type="checkbox"/> Atopic Dermatitis <input type="checkbox"/> Bruise easily <input type="checkbox"/> Carcinoma (basal/squamous cell) <input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash	<p><u>MUSCLE/JOINT/BONE PAIN</u></p> <input type="checkbox"/> Hands <input type="checkbox"/> Knees <input type="checkbox"/> Artificial joint/metal implants	<p><u>GASTROINTESTINAL</u></p> <input type="checkbox"/> Appetite loss <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<p>WOMEN only</p> <input type="checkbox"/> Irregular menstrual cycles <input type="checkbox"/> Menopause <input type="checkbox"/> Nursing <input type="checkbox"/> Pregnant <input type="checkbox"/> Other _____
<p><u>CONDITIONS</u></p> <input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Asthma <input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> Blood/bleeding disorder	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Emphysema <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Hay fever	<input type="checkbox"/> Heartburn/Reflux/ Ulcers/ Gastritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lung Disease	<input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Prostate problem <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other _____

Have you had any of the following Cosmetic treatments? (If yes, please check)

INJECTABLES:

SERVICES:

- Botox
- Microdermabrasion
- Restylane/Perlane
- Juvederm
- Facial
- Sclerotherapy
- Other _____

LASER TREATMENTS

- Fraxel
- ILP (photo facial)
- Laser Hair Removal
- Other _____

ESTHETICIAN

- Chemical Peel
- Medical Acne
- Other _____

Are you interested in learning more about any of the above treatments? Yes No
 (If yes, please list)

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