Name______________________________ Date____________________________

Preferred Pharmacy name_________________ Location_________________________

Height _________________ Weight _________________ Last 4 SSN: _____________

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD

Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol

Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

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: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other ____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? ______________________________

Medications: (Please enter all current medications)

____

____

____

Allergies: (Please enter all drug allergies)

____

____

____

Social History: (Please circle all that apply)

CigaretteSmoking:

Currently Smokes
Never Smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other ______________________________

Referring Doctor? ______________________________
First Last

Primary Care Doctor? ______________________________
First Last

ALERTS: (please circle all that apply)

Allergy to lidocaine?:______________________________

Artificial heart valve ______________________________
Artificial joint replacement ______________________________
Blood thinners ______________________________
Defibrillator ______________________________
Pacemaker ______________________________
Require antibiotics prior to a surgical procedure ______________

Are you pregnant or currently trying to get pregnant?______________

PATIENT INFORMATION □ New Patient □ Name Change □ Address Change □ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date____/____/____

Name ____
Last *First* *M.I.*

Date of Birth:____/____/____ Age: _____ Sex: □ Male □ Female

ADDRESS:

Mailing Address ____
City *State* *Zip*

Home Phone: ( )______________________Work Phone: ( )______________________

Cell Phone: ( )______________________e-mail: ______________________

PARENT, SPOUSE, OR RESPONSIBLE PARTY ***(if different from patient)***

Name:____Date of Birth:____/____/____
Last *First* *M.I.*

Address:____
City *State* *Zip*

Home Phone: ( )______________________Work Phone: ( )______________________

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:______________________________

Address of Claim Center:____

City *State* *Zip Code*

Name of Policy Holder (Insured):______________________________

Policy Holder (Insured) Date of Birth:____/____/____

Policy#:______________________ Group Name or #:______________________

Policy Type: □ HMO □ PPO

If patient is child, check relationship to insured: □ Mother □ Father □ Other______________________

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:______________________________

Address of Claim Center:____

City *State* *Zip Code*

Name of Policy Holder (Insured):______________________________

Policy Holder (Insured) Date of Birth:____/____/____

Policy#:______________________ Group Name or #:______________________

Policy Type: □ HMO □ PPO

If patient is child, check relationship to insured: □ Mother □ Father □ Other______________________

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.

Notice of Patient Privacy/Patient Consent Form

I understand that as part of my healthcare, Teche Dermatology originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Teche Dermatology *Notice of Privacy Practices* provides specific information and complete description of how my personal information may be used and disclosed. I understand that a copy of the *Notice of Privacy Practices* is available at the front desk and understand that I have the right to review the notice prior to signing this consent. I understand that Teche Dermatology reserves the right to change the *Notice of Privacy Practices.* Prior to implementation of the revised *Notice of Privacy Practices* , the revised *Notice* will be mailed to me if I provide my address below. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that Teche Dermatology is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Teche Dermatology has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

NOTE: Teche Dermatology must obtain your written authorization to use your Private Health Information for any purpose other than treatment or billing. If you want Teche Dermatology to have access to disclose your Private Health Information to your spouse or any other person during your treatment, please sign below.

I agree to allow Teche Dermatology to disclose my Private Health Information
(including date/time of appointments) to:

___ Spouse____Tel (____)_____- _______
(print name)

___ Family Member(s)__________________________________Tel (_____)_____- _______
(print name)

___ Other (i.e. friend, physician etc.)______________________Tel (_____)_____- _______
(print name)

___ Myself only, no other family member
This does not serve as an Authorization to Release Medical Records

I further understand that any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I understand that I have access to or have reviewed Teche Dermatology *Notice of Privacy Practices* for the following medical practice:

Teche Dermatology
101 Rue Fontaine Building 4
Lafayette, Louisiana 70508
Tel: 337-385-5861
Privacy Official: John Chapman – Security Officer

A copy of this agreement may be used with the same effectiveness as an original.

Print Name of Patient/Legal Representative ___________________________________ Date___/___/___

Signature of Patient/Legal Representative ____________________________________ Patient Date of Birth___/___/___