

BOONE DERMATOLOGY CLINIC, P.A.

Ronald J. Stanley, M.D.



J.F. "Peck" Garner, II, M.D.



D. Stanton Whittaker, Jr., M.D.

Aaron Westphal, M.D.



Brett T. Summey, Jr., M.D.



Katherine C. Caggiano, MS, PA-C

Please Print

Name _____ Date _____
(First) (Middle) (Last)

Address _____ Phone () _____

City _____ State _____ Zip _____ CellPhone () _____ Sex _____

Winter Address (if applicable) _____ State _____ Zip _____

Winter Telephone _____

Birthdate _____ Age _____ Patient SS# _____

Single Married Widowed Divorced Separated

Occupation _____ Employed By _____ Bus. Phone () _____

Please list the name of a person we may contact in case of emergency:

Name _____ Relationship _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employed By _____ Bus. Phone () _____

PHYSICIAN INFORMATION

Family Physician _____ Physician Phone () _____

HEALTH INSURANCE

Medicare No. _____ Medicaid No. _____

Name of Other Insurance Carrier(s)

1. _____

Group No. _____

2. _____

Group No. _____

Address of Company _____

Policy Holder's Name _____

Subscriber # or ID # _____

I AUTHORIZE BOONE DERMATOLOGY CLINIC TO TREAT MY SKIN CONDITION AND FURTHER AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER. I ALSO AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

Signed _____

Date _____

•Please check either YES or NO for the following questions. •

YES NO 1. Were you referred for **Today's Visit** by another doctor? **If yes**, give name of doctor: _____

YES NO 2. Are you allergic to any medications? Please list: _____

YES NO 3. Are you allergic to **Latex**? _____

YES NO 4. Are you allergic to **Lidocaine** or **Xylocaine** (local anesthetics)? _____

YES NO 5. Are you taking any prescription medications? Please list: _____

YES NO 6. Are you taking any non-prescription, over-the-counter medications (vitamins, antacids, laxatives, cold remedies, aspirin, etc.)? Please list: _____

YES NO 7. Are you now being treated by a doctor? If yes, for what? _____

YES NO 8. Do you have high blood pressure, tuberculosis (T.B.), diabetes, glaucoma, or ulcers (stomach or duodenal)? Please circle.

YES NO 9. Do you have an artificial heart **pacemaker**?

YES NO 10. Is there anything else we should know about your health? (Such as recent surgery, faint easily, excessive scarring, etc.)

YES NO 11. FOR WOMEN: Are you **pregnant**?

YES NO Are you taking hormone or birth control pills? YES NO Are you breast feeding?

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

This will remain in effect for a year from this date.

NEW PATIENTS ONLY

Name: _____

These questions pertain to your current skin problem:

1. What type of problem are you having? (rash, growths, warts, acne, etc.)

2. How long have you had this skin problem? _____

3. Please **draw** on this chart where your present skin problem or rash is by marking x's on the figure.

4. Has a doctor given you anything for your skin problem? If yes, please give names of **everything** used:

5. Have you applied anything else on the skin problem yourself? If yes, please give names of **everything** used: _____

