

BOONE DERMATOLOGY CLINIC, P.A.

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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?