SENTER DERMATOLOGY - PATIENT DATA SHEET – PLEASE PRINT

*****Please Note*** If this form is not filled out completely, we will not be able to submit to your insurance.**

UPDATE INITIALS

Today's Date: ________/________/_________ Patient Date Of Birth: ________/________/_________ _______

Patient Name: ______________________________ ________ ____ _______
FIRST M.I LAST

Address: ____________________________________ ______________________________ _________ ____________ _______
STREET CITY STATE ZIP CODE

Home Number: ______________________ Work Number: ________________________ Cell Number:_____________________ _______

**** MAY WE LEAVE MESSAGES WITH MEDICAL INFORMATION AT THE NUMBERS LISTED ABOVE? ☐ Yes ☐ No ****

Gender: ☐ Male ☐ Female Marital Status: ☐ D ☐ M ☐ S ☐ W _______

SSN# ________________________ Email address: ____ _______

Occupation: _______________________________ Employer:____ _______

Emergency Contact & relation to patient: _____________________________________ Contact Number: __________________ _______

Any family members who are patients here? If so, please list: ____ _______

Who is responsible for this account? _________________________________ Contact Number(s): ________________________ _______

Address: _______________________________________ ______________________________ _________ ___________ _______
STREET CITY STATE ZIP CODE

Please list the name(s) and phone number(s) of all those that you give us permission to speak to regarding your care here:____

____ _______

MEDICAL HISTORY

Are you allergic to any medications? ☐ Yes ☐ No Any other Allergies? ☐ Yes ☐ No

If yes, please list: ____________________________________ If yes, please list:_________________________________

____ ____

____ ____ _______

Are you taking any medications? (Prescribed/Over the Counter) ☐ Yes ☐ No If yes, please list: ______________________

____

____

____ _______

What is your preferred Pharmacy? ____________________________ Location: _____________________________________ _______

Who is your Primary Care Physician? _____________________________ Contact Number:_____________________________ _______

Are you seeing any other Physicians at this time? If so, please list: ____

____ _______

Do you or any family member have a history of skin cancer? If so, who and what kind?___________________________________

____

____ _______

General medical history:

____

____

____ _______

DATE

____ Relationship to Patient:______________________________ ________

SIGNATURE

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY

ALLERGY/IMMUNO.	CARDIO-VASCULAR	SKIN	GE/GU	EYES/NOSE/EARS	PULMONARY
Food Allergy Hay Fever Lupus Rheumatoid Arthritis Scleroderma Vasculitis	High Cholesterol High Triglycerides Hypertension Heart Attack Blood Clots/DVT	Acne Eczema Herpes Keloids Melanoma Skin Cancers Warts Ulcers Cold Sores	Hemorrhoids Hiatal Hernia Hepatitis Stomach Ulcer Renal failure/dialysis Kidney Stones	Cataracts Glaucoma Deafness Sinus issues	Asthma Emphysema Tuberculosis
PSYCHIATRIC	**MUSCULO-SKEL**	**ENDOCRINE**	**BLOOD**	**NEUROLOGIC**	**OTHER**
Anxiety Depression Dementia	Arthritis Injury	Diabetes Hypothyroid Hyperthyroid	Anemia Transfusions	Stroke Dementia	______________ ______________ ______________ ______________ ______________ ______________

SYSTEMS REVIEW: CHECK ALL THAT APPLY

GENERAL	CARDIO-VASCULAR	ENT	GU	ALLERGY/IMMUNO.	PSYCHIATRIC
Appetite change Chills Dizziness Excess thirst Fatigue Fever Night Sweats Nausea or Vomiting Weight Change	Chest pain/tightness Heart murmur Legs swelling Palpitations	Bleeding gums Dry mouth Mouth ulcers Sinus Drainage Hard of hearing Ringing in ears	Blood in urine Discharge Painful urination	Watery eyes Sneezing	Memory problems Panic attacks Suicidal thoughts Suicide attempt Anxiety Depression Dementia
PULMONARY	**EYES**	**GI**	**ENDOCRINE**	**MUSCULO-SKEL**	**NEUROLOGIC**
Shortness of breath Wheezing	Dry eyes Light sensitivity Yellowing of eyes	Black/bloody stools Constipation Diarrhea Heartburn Stomach pain Trouble swallowing	Abnormal hair growth Flushing Menstrual problem	Back pain Joint pains Joint swelling Leg cramps	Blackouts Headaches Numbness

HEMATOLOGIC	SKIN	OTHERS			
Bleeding tendencies Easy bruising Swollen lymph node(s) Anemia	Blisters Itching Lesions/growths Nail changes Pigment loss Sun sensitivity Changing moles	X-ray therapy Chemotherapy			

Blood borne illness or sexually transmitted disease? (Check all that apply)	Surgical History (Check all that apply)	Social History
HIV/AIDS Hepatitis Herpes: Genital or Oral Other:- ___________________________	Do you need antibiotics before procedures? Yes No Pacemaker/Defibrillator CABG (Bypass) Heart valve repair or replaced: Left/Right Knee replacement: Left/Right Hip replacement Appendectomy Hysterectomy Other	Smoke: #/packs/day __________ Drink alcohol: drinks/day_______ Recreational Drugs:_____________ ___________________________________ ______________________________________ **FEMALES ONLY** Are you pregnant? yes no Trying to conceive? yes no Breastfeeding? yes no On hormonal replacement therapy? yes no

FAMILY HISTORY: CHECK ALL THAT APPLY (RELATION EXAMPLE: Mother, Father, Grandmother/Father)

Condition	Relation	Condition	Relation
Diabetes	Relation:	Basal Cell Skin Cancer	Relation:
High Cholesterol	Relation:	Squamous Cell Cancer	Relation:
Cancer	Relation:	Melanoma	Relation:
Asthma	Relation:	Lupus	Relation:
Eczema	Relation:	Hypertension	Relation:
Arthritis	Relation:	Heart Disease	Relation:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

USES AND DISCLOSURES OF HEALTH INFORMATION TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Senter Dermatology uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care provider for confirmation of diagnosis;
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
- Reviewing information as part of our quality improvement program.

Other Uses and Disclosures

Senter Dermatology may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Provide you with information related to your health;
- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
- Public health activities when requested by public health authority or the FDA;
- Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discover request or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans' affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to public or private disaster relief agencies;
- Informing a family member, other relative or close personal friend when: Information is relevant to the individual's involvement with your care;
- To assist in your health care (e.g. pick-up prescription or other documents, note follow up care instructions, etc.).

Authorization for Other Uses

Senter Dermatology will make other uses or disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice you may revoke your authorization.

Your Rights Regarding the Privacy of your Health Information

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses or disclosures. However, Senter Dermatology is not obliged to agree to requested restrictions.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions.
- Amend your health information.
- Receive an accounting of disclosures of your health information.
- Obtain a copy of this notice.

Senter Dermatology Regarding the Privacy of your Health Information

Subject to limitations outlined by law, Senter Dermatology has certain duties related to your protected health information, including:

- Senter Dermatology is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Senter Dermatology is required to abide by the terms of the privacy notice that is currently in effect.
- Senter Dermatology reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacted Senter Dermatology or the Secretary for the Department of Health and Human Services. NO individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I received a copy of this notice regarding the use and disclosures of my health information.

X: ________________________________ ____________________________________ ______/______/_______

Signature **Printed Name** **Date**