

Murphy Dermatology & Aesthetics

Patient's Name: _____ DOB: _____ Age: _____ Sex: M or F

Cell Phone: _____ Home Phone: _____

Preferred Method of Contact: Cell or Home Email Address: _____

Home Address: _____ City/State/Zip Code: _____

Preferred Pharmacy: _____ Pharmacy City/State/Zip Code: _____

Primary Care Doctor: _____ Primary Care Doctor's Phone: _____

How did you hear about us? _____ Do you have a healthcare proxy? YES/NO _____

PAST MEDICAL HISTORY

(Circle all that apply)

Anxiety

Depression

Leukemia

Arthritis

Diabetes I/II

Lung Cancer

Asthma

End Stage Renal Disease

Lymphoma

Atrial fibrillation

GERD

Prostate Cancer

Bone Marrow Transplantation

Hearing Loss

Radiation Treatment

Breast Cancer

Hepatitis

Seizures

Colon Cancer

High Blood Pressure

Stroke

COPD

HIV/AIDS

Thyroid Problems

Coronary Artery Disease

High Cholesterol

Other: _____

DO YOU HAVE A HISTORY OF SKIN CANCER?

Y or N

(Circle all that apply)

Basal Cell Skin Cancer

Melanoma

Squamous Cell Skin Cancer

Patient's Name: _____ DOB: _____

MEDICATIONS: please include dose, route, and frequency

ALLERGIES: please include their reactions

SOCIAL HISTORY: (circle the options that apply)⁶⁵⁴

Smoking Status:

Current everyday smoker

Current some day smoker

Former Smoker

Never Smoker

Alcohol Use:

3 or more drinks per day

1 to 2 drinks per day

Less than 1 drink per day

None

Do you have an allergy to lidocaine? Y or N

Female patients: are you pregnant or plan to become pregnant? Y or N

INSURANCE INFORMATION

**** INSURANCE INFORMATION MUST BE FILLED OUT REGARDLESS IF WE OBTAIN A COPY ****

Primary Insurance: _____ ID #: _____

Name of Policy Holder (Self/Spouse/Parent): _____ Policy Holder's DOB: _____

Secondary Insurance: _____ ID #: _____

Name of Policy Holder (Self/Spouse/Parent): _____ Policy Holder's DOB: _____

Tertiary Insurance: _____ ID #: _____

Name of Policy Holder (Self/Spouse/Parent): _____ Policy Holder's DOB: _____

Name of Guarantor - person who is responsible for payments - (Self/Spouse/Parent): _____

I understand that I have insurance coverage with the insurance carrier(s) above. I understand I am responsible for all charges – including copays, deductibles, and co-insurances – for services rendered regardless if reimbursed by my insurance.

PATIENT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

(parent/guardian if patient is under 18 years of age)

PERMISSION TO LEAVE HEALTH INFORMATION WITH FAMILY/FRIENDS

By signing below, I gave permission to the person(s) listed below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my healthcare and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission is considered ongoing until I state in writing otherwise.

THE STAFF HAS MY PERMISSION TO LEAVE A MESSAGE WITH:

(This is optional)

Date of Permission	Name of Individual & Relationship	Telephone Number	Patient's Initials

PERMISSION TO LEAVE HEALTH INFORMATION WITH SELF

THE STAFF HAS MY PERMISSION TO:

(Check all that apply)

<input type="checkbox"/>	Only leave a message on my voicemail to return phone call	Phone Number: _____
<input type="checkbox"/>	Leave detailed message on my voicemail	Phone Number: _____

PATIENT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

(parent/guardian if patient is under 18 years of age)

Murphy Dermatology & Aesthetics

Francis P. Murphy, MD Board Certified Dermatologist
Christine Doering, PA-C Dermatology Physician Assistant
Kellie Cummings, PA-C Dermatology Physician Assistant
819 Little Britain Road, Suite 100 New Windsor, NY 12553
P: (845) 500-1985 | F: (845) 522-8888
murphyderm.com

REQUEST OF MEDICAL RECORDS

This form is optional. This form is allowing Murphy Dermatology Group to send your medical records to another doctor OR allowing another doctor to send your medical records to Murphy Dermatology Group. If you choose to fill out this form, please fill it out in its entirety.

I _____ authorize the request of the below patient's medical records:

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Address: _____

Patient's Signature: _____

Today's Date: _____

Relationship to Patient: self parent spouse other: _____

Release records to / Obtain records from:
(circle only one)

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone: _____

Doctor's Fax: _____

Additional Note: _____