Murphy Dermatology Group

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

Cell Phone: _____ Home Phone: _____

Preferred Method of Contact: Cell or Home

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

Preferred Language: _____ Email Address: _____

Marital Status: _____ Race/Ethnic Group: _____

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

Primary Care Provider: _____ Phone: _____

Do you have an allergy to lidocaine? Y or N
Are you pregnant or plan to become pregnant? Y or N
Have you had the pneumonia vaccine? Y or N

Past Medical History

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes I or II	Hyperthyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial Fibrillation	GERD	Lung Cancer
Bone Marrow Transplant	Hearing Loss	Lymphoma
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood Pressure	Radiation Treatment
COPD	HIV/AIDS	Seizures
Coronary Artery Disease	High Cholesterol	Stroke

Other: _____

Past Surgical History

_____

_____

Skin Disease History

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Other: _____

Do you wear sunscreen? Y or N If yes, what SPF? _____
Do you tan in a tanning salon? Y or N
Do you have a family history of Melanoma? Y or N If yes, which relative(s)?_____

Medications: include dose, route, and frequency

_____

_____

_____

Allergies: include their reactions

_____

_____

Social History:

Smoking Status:	Alcohol Use:
Current every day smoker	3 or more drinks per day
Current some day smoker	1 to 2 drinks per day
Former Smoker	Less than 1 drink per day
Never Smoker	None

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): _____

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

PATIENT NAME: _____ ***SIGNATURE:*** _____ ***DATE:*** _____
(parent/guardian if patient is under 18 years of age)

PATIENT CONSENT FORM

The Department of Health Services has established a "Privacy Rule" to help ensure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information, payments, or healthcare operations in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical. We have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes for treatment, payment, or healthcare operations. These entities are most often required to obtain patient consent.

You may refuse to consent the use or disclosure of your Personal Health Insurance (PHI), but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose you PHI. If you choose to give consent to this document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken while relied on this or previously signed consent. You have the right the review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

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)

	Only leave a message on my voicemail to return phone call	Phone Number:
	Leave detailed message on my voicemail	Phone Number:
	Send information to my email	Email:

PATIENT NAME: _____ ***SIGNATURE:*** _____ ***DATE:*** _____
(parent/guardian if patient is under 18 years of age)

Murphy Dermatology Group

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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: _____

Date of Birth: _____

Address: _____

_____

Signature: _____

Date: _____

Relationship to Patient: self parent spouse guarantor other: _____

Release records to / Receive records from:
(circle one)

_____

Address: _____

Phone: _____

Fax: _____

Additional Note: _____