Murphy Dermatology Group

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

Preferred Method of Contact: Cell or Home

Cell Phone: _____ Home Phone: _____

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

Marital Status: _____ Email Address: _____

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

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

Do you have an allergy to lidocaine? Y or N Females: are you pregnant or plan to become pregnant? Y or N

DO YOU HAVE A HISTORY OF SKIN CANCER?

(Circle all that apply)

Basal Cell Skin Cancer Melanoma Squamous Cell Skin Cancer

MEDICATIONS: please include dose, route, and frequency

_____

_____

_____

ALLERGIES: please include their reactions

_____

_____

SOCIAL HISTORY: (circle the options that apply)

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 - (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)

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

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

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

Murphy Dermatology Group

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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: _____