CENTER FOR DERMATOLOGY
ERIK B. HURST, MD

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)		SOCIAL SECURITY #	
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL/ALTERNATIVE PHONE	
EMAIL ADDRESS			
SEX: MALE FEMALE	MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED	DATE OF BIRTH:	HAVE YOU BEEN SEEN IN THE OFFICE BEFORE?

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	NAME OF POLICY HOLDER/ RELATIONSHIP TO PATIENT/ D.O.B.	
ID NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER
SECONDARY INSURANCE COMPANY	NAME OF POLICY HOLDER/ RELATIONSHIP TO PATIENT/ D.O.B.	
ID NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

EMERGENCY CONTACT

NAME (LAST, FIRST, MI)	RELATIONSHIP TO PATIENT
PRIMARY PHONE	CELL/ALTERNATIVE PHONE

GUARANTOR/RESPONSIBLE PARTY

GUARANTOR NAME	DATE OR BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP	DAYTIME PHONE	
ADDRESS		

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any otherwise payable to me for his/her services as described, realizing I am responsible for non-covered services.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature: _____ Date: _____

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MEDICAL HISTORY AND INTAKE FORM

DATE: _____ **DOB: _____**

PATIENT NAME: _____

PRIMARY CARE PHYSICIAN: _____

MEDICATION ALLERGIES: _____

PHARMACY NAME: _____

PHARMACY ADDRESS & PHONE NUMBER: _____

_____

PAST MEDICAL HISTORY:

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH (Enlarged Prostate)
Cancer Types:
_____
_____
_____

COPD
Coronary Artery Disease
Depression
Diabetes
Kidney Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS

Hypercholesterolemia
Hyperthyroid
Hypothyroid
Radiation Treatment
Seizures
Stroke
Other:
_____
_____
NONE

HAVE YOU HAD SURGERY ON ANY OF THE FOLLOWING ORGANS? (please circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Lumpectomy: _____
Breast: Mastectomy: _____
Breast: Breast Biopsy
Colon: Colon Cancer resection
Colon: Diverticulitis
Colon: Inflammatory Bowel Disease
Colon: Colostomy
Gall Bladder (Cholecystectomy)
Heart: Coronary Artery Bypass Surgery
Heart: PTCA
Heart: Mechanical valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement: _____
_____
_____

Kidney: Biopsy
Kidney: Nephrectomy
Kidney: Stone Removal
Kidney: Transplant
Liver: Shunt
Liver: Liver Transplant
Liver: Hepatectomy
Ovaries: Endometriosis
Ovaries: Cyst
Ovaries: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreatectomy
Prostate Biopsy
Prostate: TURP
Rectum: APR
Rectum: Lower Ant. Resection
Skin: Biopsy
Skin: Basal Cell

Skin: Squamous Cell
Skin: Melanoma
Spleen: Splenectomy
Testicles: Orchiectomy
Uterus: Fibroids
Uterus: Uterine Cancer
Uterus: Cervical Cancer
Other: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY AND INTAKE FORM (PAGE 2)

SKIN DISEASE HISTORY: (circle all that apply):

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

Do you wear sunscreen? _____ If yes, what SPF _____ Do you tan in a tanning salon?_____

Do you have a family history of melanoma? _____If yes, which relative(s)?_____

SOCIAL HISTORY:

Smoking Status: (please circle one)
Current every day smoker
Occasional smoker
Former Smoker
Never Smoker

Alcohol Status: (please circle one)
None
Several times per month
several times per week
1-2 drinks per day
More than 3 drinks per day

FAMILY HISTORY (PLEASE CIRCLE ALL THAT APPLY AND INDICATE RELATIONSHIP TO YOU OR PATIENT):

Acne: _____ Arthritis: _____

Asthma: _____ Diabetes: _____

Eczema: _____ Hayfever/ Allergies: _____

Lupus: _____ Psoriasis: _____

Non-melanoma Skin Cancers: _____

REVIEW OF SYSTEMS: Do you have or are you currently experiencing any of the following?
(Please circle all that apply)

Changing mole	Muscle weakness	Rash
Neck stiffness	Fever or chills	Headaches
Depression	Seizures	Anxiety
Cough	Problems with healing	Shortness of breath
Problems with bleeding	Wheezing	Problems with scarring
Pacemaker	Defibrillator	Hay fever
Blood thinners	Chest pain	GI upset w/antibiotics
Night sweats	Thyroid problems	Immunosuppression
Unintentional weight loss	Rapid heartbeat with epinephrine	Joint aches
Pregnancy or planning a pregnancy	MRSA	Bloody urine
Sore throat	Allergy to adhesive	Other:_____
Allergy to lidocaine	Abdominal Pain	_____
Allergy to topical antibiotic ointment	Artificial heart valve	_____
Artificial joint within the past 2 years	Premedication prior to surgery	_____
Blurry Vision	Bloody Stool	_____

IMMUNIZATIONS: Have you had the following immunizations?

Influenza (flu): _____ Date: _____ COVID-19: ____ Date: _____

Pneumonia: _____ Date: _____ Varicella (Shingles) ___ Date: _____