Brandon Dermatology Patient Information

Name (Last, First, MI): _____

Male □ Female □ Marital status: _____ Date of Birth: ____ / ____ / ____ Age: _____
Race: White☐ Black/African American☐ Hispanic☐ Asian☐ Other_____
Preferred Language: English☐ Spanish☐
YES! Please email me Brandon Dermatology's specials, events and office updates☐

Social Security #: _____ - _____ - _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____Cell Phone: (____) _____ Work Phone: (____) _____

Driver's license #:_____State:_____

E-Mail Address:_____

Employer: _____ Occupation:_____

To notify in case of emergency: _____ Relationship: _____

Phone: (____) _____

Primary Care Physician:_____ Phone: (___) _____

Have any of your family members been seen here before? Y / N

If yes, Name:_____

Insurance Information:

□ Medicare and Secondary □ Medicare Replacement

□ Primary Insurance Company:_____

□ Secondary Insurance Company:_____

Please have your insurance card(s) ready so that we can scan into your chart.

If patient is not the policyholder, complete below:

Policy Holder Name (Last, First, MI):_____

Relation to Patient: _____ Phone: (_____)_____

Social Security #: _____ - _____ - _____ Male □ Female □ Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: (____) _____

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Patient/Parent/Authorized Representative Name: _____

Signature:_____ Today's Date:_____
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Brandon Dermatology Medical History

Patient: _____Date of Birth: ____/____/_____ Age: _____
(Last) (First) (M.I.) Male ☐ Female ☐

Personal History: (please check all appropriate boxes)

Arthritis/Joint Pain Yes ☐ No ☐
Artificial joint Yes ☐ No ☐
Cancer Yes ☐ No ☐
If yes, type: _____
Depression Yes ☐ No ☐
Multiple Sclerosis Yes ☐ No ☐
Thyroid Disease Yes ☐ No ☐
Kidney Disease Yes ☐ No ☐
Chron's/Colitis Yes ☐ No ☐
Liver Disease Yes ☐ No ☐
Gastric Ulcers Yes ☐ No ☐

Pacemaker Yes ☐ No ☐
Defibrillator Yes ☐ No ☐
Heart valve surgery Yes ☐ No ☐
High blood pressure Yes ☐ No ☐
Bleeding disorder Yes ☐ No ☐
Hepatitis Yes ☐ No ☐
AIDS/HIV Yes ☐ No ☐
Herpes/cold sores Yes ☐ No ☐
Tuberculosis Yes ☐ No ☐

Skin disease Yes ☐ No ☐
If yes, please list: _____
_____

Skin cancer Yes ☐ No ☐
Keloids Yes ☐ No ☐

Other_____
Medication prior to dental cleaning/procedures Yes ☐ No ☐

Family History:
Has anyone in your family had skin cancer? Yes ☐ No ☐ If yes, what type: _____

Medications: (please list ALL medicines including aspirin, birth control pills, vitamins/supplements, diet pills)
_____
_____
_____

Allergies to Medications: Yes ☐ No ☐ (please list)
_____
_____

Surgery: (list all) _____

Social History:
Do you smoke? Yes ☐ No ☐
Do you use snuff/smokeless tobacco? Yes ☐ No ☐

Occupation: _____Employer:_____

Women: (Please Complete)
First day of last menstrual cycle: _____
Pregnant: Yes ☐ No ☐
Breast-feeding: Yes ☐ No ☐

How did you hear about our practice: _____ Referred by: _____

I acknowledge that I have completed the above information to the best of my ability.

Patient Name: _____ Patient Signature_____ Date: _____