



Semler Dermatology, Inc.

New Patient / Patient Update Information Sheet

Name: _____	Address: _____
City/State/Zip: _____	Date of Birth: _____
Email: _____	
Phone(Home) _____	Phone(Work/Cell): _____
Sex: M F Marital Status: _____	
Did your doctor or other medical provider request this consultation today? YES NO	
Today's consultation was requested by: _____ Primary Doctor: _____	

PRIMARY INSURANCE COVERAGE	
Responsible party (if patient is a minor) _____	
Primary Insurance: _____	ID# _____ Grp# _____
Subscriber (if different than patient) _____	Subscriber's DOB: _____
Secondary Insurance: _____	IDI# _____ Grp# _____
Subscriber (if different than patient) _____	Subscriber's DOB: _____

Pharmacy (include City or street): _____
Patient's Employer: _____ Occupation: _____
Emergency contact: _____ Phone: _____

We will bill your insurance company if we participate with that company. You are responsible for any and all charges that your insurance company does not cover such as deductibles, co-pays and non-covered services, which are payable at the time of service. For your convenience, we accept Visa and MasterCard. Parents are responsible for payments on child accounts. All tissue removed will be sent for pathologic examination. I authorize for insurance payments to go directly to physician and for release of necessary medical records to the insurance company to receive payment.

HMO participants: In order for your insurance to pay for your visit, it is **your** responsibility to obtain referrals from your primary care physician for **each visit**. I have had the opportunity to review the corporation's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I certify that I understand the above and that the information I have given is correct to the best of my knowledge.

I have read and reviewed the outside billing agency policy.

Please provide the name of person(s) to whom you would permit Semler Dermatology to disclose personal health information as necessary for your continued health care:

Cancellation Policy: Patients who do not give at least 24 hour cancellation for a scheduled appointment are subject to a \$30.00 fee for office visits and \$50.00 for procedures.

Patient Signature (if patient is a minor, signature of parent or guardian is required) Date

New Patient History

Welcome to the office of Semler Dermatology, Inc. This form is a permanent part of your medical record. Please complete this form as carefully and completely as possible.

Name: _____

What is the reason for your visit?

PAST MEDICAL HISTORY and/or CURRENT MEDICAL PROBLEMS: Please list any and all dermatologic or medical conditions that you have had or currently have (i.e. skin cancer [melanoma or other type], abnormal mole [atypical or dysplastic], heart disease, pacemaker, high blood pressure, high cholesterol, diabetes, asthma, arthritis, or any type of cancer).

Medication allergies:

Do you take aspirin or any other blood thinners? Yes No			
Current Medications:			Supplements / Herbals:
Name	Strength	How often	

Name: _____

Prior surgeries:	
Do you have a pacemaker? Yes No	
Do you have any artificial joints? Yes No	
Do you have any artificial heart valves? Yes No	

Dermatologic Family History: (please make a check mark if members of your family have/had these conditions:					
	Mother	Father	Sister	Brother	
Asthma					
Atypical (dysplastic) moles					
Diabetes					
Eczema					
Melanoma					
Psoriasis					
Skin cancer (Non-Melanoma)					

Do you drink alcohol?
Do you smoke?
Do you use sunscreen? Always Sometimes Never
History of tanning bed use? In the past Current

For Women: Are you currently -
Pregnant? Yes No
Trying to become pregnant? Yes No
Nursing? Yes No