PSORIASIS AND ECZEMA TREATMENT CENTER

PATIENT INFORMATION

Name _____ Date of Birth _____ Sex: M F Mar. Status _____
Last Name First Name M.I.

Address _____
Street address City State Zip +four Social Security #

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation: _____ Employment Status: FT PT NONE Student Status: FT PT NONE

RESPONSIBLE PARTY: (if patient is a minor)

Name _____ Home Phone _____ Cell Phone _____

Address _____
Street address City State Zip +four Date of Birth

PRIMARY IN SURANCE

Subscriber Name: _____ Subscriber birthdate _____

Group# _____ Insured's ID# _____ Relation to Subscriber _____

Employer Name _____ City _____

SECOND INSURANCE

Subscriber Name: _____ Subscriber birthdate _____

Group# _____ Insured's ID# _____ Relation to Subscriber _____

In case of Emergency, who should be notified: _____ Phone _____

Other Family members who are patients _____

Pharmacy of Choice _____ Phone _____

Primary Care Physician _____ Did they refer you? _____

Release of Medical/Financial Information - You must give us permission to talk with others about your medical care or billing information. Unless their name is listed below, we may not speak to them about your care or your bill. Please indicate your emergency contact.

Name	Relationship	Home Phone	Mobile Phone	☐ Medical	☐ Billing	☐ ER contact

PSORIASIS AND ECZEMA

TREATMENT CENTER

Your Privacy:

I have been informed of the Notice of Privacy Practices for Psoriasis and Eczema Treatment Center.

Signature _____ Date _____

Financial Policy: Patients who are covered by a private, commercial plans in which our physicians do not participate are required to pay 100% of the bill at the time of service. If covered by a plan with whom we have a contract, applicable co-payments and deductibles will be collected at the time of service, if determinable. You are responsible for paying for 100% of non-covered or cosmetic services. Payment for amounts billed to you are due within 20 daysof receiving a statement. Your signature indicates your willingness to comply with this policy.

Signature _____ Date _____

Authorization for Payment: I authorize the release of information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits directly to the physician.

Signature _____ Date _____

Special Authorization for Medicare Patients Only:
I request that payment of authorized Medicare benefits be made on my behalf to Psoriasis and Eczema Treatment Center for any services furnished me by their providers. I authorize the release of information to the Centers for Medicare and Medicaid Services and its agents in order to determine benefits and payment of the claim. If "other health insurance" Is indicated I authorize releasing of the information to the insurer or agency shown. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for co-insurance and deductible amounts as directed by my Medicare carrier. (Psoriasis and Eczema Treatment Center is a participating provider.)

Signature _____ Date _____

How did you hear about us? Doctor Friend Family Member Yellow Pages

PSORIASIS AND ECZEMA
TREATMENT CENTER

ADULT HEALTH HISTORY FORM

Today's Date:_____

NAME _____ Date of Birth:_____ Age:_____

PRIMARY CARE PROVIDER _____

Were you referred?_____Yes _____No

TELEPHONE NUMBER to reach you with information or results _____

MEDICAL HISTORY:

1. Major Illnesses/Hospitalizations/Chronic conditions _____

_____

2. Surgeries _____

_____

3. Family history of illness or chronic disease? Please Circle.
   Psoriasis, Eczema, Skin Cancer, High Blood Pressure, Diabetes, Multiple Sclerosis, Cancer (any type), Osteoarthritis, other: _____

4. **DO YOU** have any of the following? Please Circle.
   Psoriasis, Eczema, Skin Cancer, High Blood Pressure, Diabetes, Multiple Sclerosis, Cancer (any type), Osteoarthritis, Congestive Heart Failure, Depression, Anxiety, High Cholesterol/Triglycerides, Hypothyroidism, other. _____

_____

DO YOU SMOKE?_____Yes_____No_____Sometimes
DO YOU DRINK ALCOHOL?_____Yes _____No _____Sometimes **HOW MUCH?**_____

MEDICATIONS: (Include creams and vitamins)

Name	Name
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

ALLERGIES TO MEDICATIONS: _____
Allergy to latex:_____Yes_____ No Allergies to food or environment?_____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____
How long have you experienced these symptoms?_____

Check all treatments that you have used _____Topicals (creams/ointments)
_____Light Therapy _____Methotrexate_____Soriatane _____Cyclosporine_____ Prednisone
_____Biologics (Enbrel, Humira, Remicade, Stelara) please circle

Check symptoms:_____Severe itching_____Physical pain_____Unable to sleep

IMPACT ON DAILY LIFE

Do your symptoms cause you to feel depressed, self-conscious or withdrawn?
_____Not at all _____Sometimes _____All the time

What other ways does your skin condition affect you? _____