INGLETON DERMATOLOGY

Adult and Pediatric Dermatology
Cosmetic Dermatology
Laser Surgery

Today's Date:_____ **Please show all insurance cards.**

Patient's Name (Last)_____ (First)_____

Street Address_____

City_____ State_____ Zip Code_____

Home #_____Work _____ Cell:_____

*E-mail Address_____ Pharmacy #_____

Sex: Male ( ) Female ( ) Date of birth_____ Age_____ SS#_____

Marital Status_____ Name of Spouse_____

Emergency Contact_____ Relation_____

Telephone (Day)_____ (Evening)_____

Are you employed? Yes ( ) No ( ) If yes, what is your occupation?_____

Name of employer_____

Work Address_____

Did your Primary Care Physician refer you? Yes ( ) No ( ) PCP Name_____

PCP Telephone_____ PCP Address_____

If no, how were you referred?_____

INSURANCE INFORMATION
What is your ***PRIMARY*** Insurance?_____

I understand that it is my responsibility to know if Ingleton Dermatology is in network with my insurance plan. I have contacted my insurance provider, and I have received confirmation that Ingleton Dermatology is in network. I also understand that if Ingleton Dermatology is not in network with my insurance, I am responsible for any charge(s) that I may incur.

I understand that if my insurance carrier requires a referral, I will bring a referral or assume financial responsibility for all charges incurred. In addition, it is my responsibility to inform Dr. Ingleton's staff of any changes with regard to my insurance coverage prior to my visit. I will also assume financial responsibility for all charges incurred if I fail to present verification of insurance coverage (ID Card).

I authorize payment of medical benefits to the Physician for all services provided. Some insurance carriers will only pay for services that are determined to be "medically reasonable and necessary." I understand that if my insurance carrier determines a particular service not to be "reasonable and necessary" they may deny coverage for that service. In the event that coverage is denied, I agree to be responsible for payment.

If you provide an e-mail address to us; we may e-mail office correspondences and billing statements to you from time to time. If you do not want either of these, please check the box(es) below:

___*I do not want office announcement's or special notifications from the office e-mailed to me.*

___*I do not want statements e-mailed.*

Signature of Patient_____ Date_____

ingletonmd.com

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INGLETON

Date:_____ Name:_____

New Patient Medical Information Form

Reason for visit:_____

Past Medical History:

- List any chronic medical conditions _____
- List any known allergies to medication: _____
- List any chronic medications that you are currently taking: _____
- For women: Are you pregnant? _____ Yes _____No / Are you breast-feeding? _____ Yes _____No
- Do you have a personal history of pre-cancers / atypical moles / skin cancers? _____ Yes _____No

  If "yes", what type? _____
- Do you have any prior history of chronic skin conditions? _____ Yes _____No

  If " yes", ( ) Psoriasis ( ) Eczema ( ) Other_____

Family History:

- Is there a family history of skin cancer? _____ Yes _____No
  If known please describe (i.e., family member, type of cancer)_____

  _____
- Any family history of skin conditions? _____ Yes _____No

  If yes, please list_____

Social History:

- Do you have occupational sun exposure? _____ Yes _____No
- Past sun exposure _____ Low _____ Moderate _____ Significant
- Daily sunscreen used on face? _____ Yes _____No

Review of Systems: (check all that apply)

_____ Fever, weight loss	_____ Swelling of feet, ankles, or hands	_____ Joint pains
_____ Varicose veins	_____ Burning of eyes, glaucoma, cataract	_____ Seizures
_____ Asthma or wheezing	_____ Changes in nails or hair	_____ Hay fever
_____ Stomach upset	_____ Anxiety, depression	_____ Rash, itching

For All Patients:

It is recommended that you have a complete examination of the skin at your first visit to a dermatologist. This requires you to be appropriately gowned to enable the doctor to examine your skin surface for any undetected benign or malignant growths. Do you wish to have this examination? _____ Yes _____ No

Name of person filling out this form (please print)_____

Relationship, if not patient:_____

Staff Initial:_____

M.D. Initial:_____