



Personal

Name: _____ Date of Birth: _____ Gender: M F

Telephone number(s): (H) _____ (C) _____ (W) _____

Email: _____

Address: _____

City: _____ ZIP: _____

Do we have permission to leave a message on your home or cell phone? Yes No

Emergency Contact: _____ Phone: _____

Primary Care Physician

Name: _____

Address: _____

Pharmacy

Name: _____

Address: _____

Medications

Allergies

Latex Lidocaine Epinephrine Other _____

Skin History

Skin Cancer? Yes No List Types(s) _____

Family History of Melanoma? Yes No Relationship: _____

Other Skin Problems _____



Medical History

Cardiac Condition? Yes No **Immunosuppressed?** Yes No **Diabetic?** Yes No

List Surgeries: _____

Smoker? Yes No **Former Smoker?** Yes No

Have you had any of the following conditions?

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> BreastCancer | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> ColonCancer | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Seizures/stroke |
| <input type="checkbox"/> Hearing Loss | |
| <input type="checkbox"/> Other significant conditions: _____ | |

Insurance Information

Name of Primary Insurance: _____ Group Number: _____

Subscriber Name: _____ Member Number: _____

Name of Secondary Insurance: _____ Group Number: _____

Subscriber Name: _____ Member Number: _____

I (the undersigned) accept responsibility for any fees not covered by my insurance.

Signature

Date



Camilla **McCalmont**, MD
Jennifer **Fu**, MD

A medical dermatology practice

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or procedure to be “not covered”, you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

I (the undersigned) accept responsibility for any fees not covered by my insurance.

Patient/Guardian Signature

Date