This form must be complete in order for insurance to be billed. I consent to the release of medical information to my insurance company and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I authorize and request that any insurance benefits be paid directly to Asarch Center for Dermatology. I understand the financial policies of this practice and agree that I am responsible for the balance on my account for services rendered. Account balances that exceed 60 days will be charged a rebilling charge of $4.00/month. I understand that tissue removed will be sent to a laboratory for pathological examination which involves additional fees.
Health History

Date ______________________

Auto-Immune disease □ Yes □ No
Type: ___________________________________
  □ Lupus
  □ Rheumatoid Arthritis
  □ Hyper/ Hypothyroidism

HIV/AIDS □ Yes □ No
Liver disease □ Yes □ No
Type: ___________________________________
  □ Hepatitis B
  □ Hepatitis C

Endocrine Disease □ Yes □ No

OB/GYN
  □ Breast Feeding
  □ Pregnant
  □ Irregular menses

Eye Disease □ Yes □ No
Type: ___________________________________
  □ Glaucoma □ Cataracts

Seasonal Allergies □ Yes □ No

Family history of skin disease & medical problems
Type: ___________________________________

Social History
Smoke □ Yes packs per day _____ □ No
Alcohol □ Yes Drinks per day_____ □ No

Psychiatric history □ Yes □ No
□ Depression □ Other
Type: ___________________________________

Other Medical Problems
List: ____________________________________

Medication Allergies:
List: ____________________________________

Medications Currently Taking:
_______________________________________
_______________________________________

Auto-Immune disease □ Yes □ No
Type: ___________________________________
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  □ Rheumatoid Arthritis
  □ Hyper/ Hypothyroidism

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□ Depression □ Other
Type: ___________________________________

Other Medical Problems
List: ____________________________________

Medication Allergies:
List: ____________________________________

Medications Currently Taking:
_______________________________________
_______________________________________
ACKNOWLEDGEMENT

I, __________________________________________, acknowledge that I have received a copy of Asarch Center for Dermatology, Notice Regarding Privacy of Personal Health Information.

________________________________________  ________________
(Signature)                             (Date)