BURKE DERMATOLOGY

REGISTRATION FORM - PLEASE PRINT **Date: _____**

****PATIENT INFORMATION****

Name: Mr. ___ Mrs. ____ Ms. _____ **Email: _____**

_____

First Name **Middle Initial** **Last Name**

Address:_____City:_____State:_____Zip_____

Phone [H] (_____) _____ [W] (_____) _____ [C] (_____) _____

Date of Birth:_____ Age: _____ Social Security Number: _____

Occupation: _____ Employer: _____

Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White

☐ Other Race Language: ☐ English ☐ Spanish ☐ Other:_____

Primary Care MD: _____Primary Care MD Phone #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

****SPOUSE****

COMPLETE IF INSURANCE IS THROUGH SPOUSE

Full name:_____ Address(If different from above): _____

City:_____ State:_____ Zip:_____ Date of Birth: _____ SS: _____

Phone [H] (_____) _____ Phone [W] (_____) _____ Phone [C] (_____)_____

Employer_____ Occupation: _____

****PARENTS****

COMPLETE IF PATIENT IS A DEPENDENT AND/OR IF PATIENT IS A MINOR

Father's Full Name: _____ Date of Birth: _____ SS: _____

Address (if different from above):_____City: _____ State: _____ Zip: _____

Phone [H] (_____)_____ [W] (_____) _____ [C] (_____)_____

Mother's Full Name: _____ Date of Birth: _____ SS: _____

Address (If different from above): _ _____City: _____ State: _____ Zip: _____

Phone [H] (_____) _____ [W] (_____) _____ [C] (_____)_____

*****Person financially responsible for patient's visit (please check): Father _____ Mother _____**

*** INSURANCE INFORMATION ***

DO YOU NEED A REFERRAL FROM YOUR (PCP) PRIMARY CARE PHYSICIAN FOR THIS VISIT ____ YES ____ NO

DO YOU HAVE A CO-PAY FOR EACH VISIT ___ YES ___ NO IF SO, WHAT IS CO-PAY AMOUNT $ _____

PRIMARY INSURANCE COMPANY

Insurance Co:_____ Co. Address: _____

Ins. Phone #: _____ Policy holder: ___ patient ___ spouse ___ father ___ mother

ID# or SSN#:_____ Grp #_____ Acct# _____

*****SECONDARY INSURANCE COMPANY*****

DO YOU HAVE SECONDARY INSURANCE ___ YES ___ NO (IF YES, COMPLETE BELOW):

Insurance Co:_____ Co. Address: _____

Ins. Phone #: _____ Policy holder: ___ patient ___ spouse ___ father ___ mother

ID# or SSN#:_____ Grp #_____ Acct# _____

*****SIGNATURE ON FILE STATEMENT*****

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE BENEFITS, BE MADE TO EITHER ME OR ON MY BEHALF TO BURKE DERMATOLOGY FOR ANY SERVICES RENDERED TO ME BY DR. THOMAS BURKE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, OR OTHER FACILITY, AND ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

BECAUSE THE OFFICE SCHEDULES IN ADVANCE, WE ASK THAT YOU KINDLY GIVE US 24 HOURS NOTICE FOR ANY CANCELLATIONS. THIS WILL ENABLE US TO USE YOUR APPOINTMENT TIME FOR ANOTHER PATIENT IF NECESSARY. WE MAY CHARGE FOR CONSECUTIVE MISSED APPOINTMENTS WITHOUT APPROPRIATE NOTICE OF 24 HOURS IN ADVANCE.

PLEASE SIGN BELOW INDICATING THAT YOU HAVE READ THE ABOVE:

SIGNATURE: _____ TODAY'S DATE: _____

Who may we release med. information to? _____ Relationship _____ Ph_____

Burke Dermatology

774 Christiana Road, Suite 107
Newark, DE 19713

1673 S. State Street, Suite A
Dover, DE 19901

Patient's Name_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____