BURKE DERMATOLOGY

REGISTRATION FORM - PLEASE PRINT Date: _____

PATIENT INFORMATION

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

_____
First Name Middle Initial Last Name

Address: _____ Unit/Apt _____ 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 _____

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 THE PROVIDERS AT BURKE DERMATOLOGY. 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_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PATIENT PRIVACY AND RIGHTS DISCLOSURE

Burke Dermatology and its employees disclose information given to us by you, your insurance company, primary care doctor and/or other medical professionals strictly for the purpose of treatment, payment of services rendered or health care operations. We do not sell mailing lists or disclose personal information about our patients except that which is needed to carry out our objective, which is your health care. In compliance with HIPAA guidelines, the patient understands they have the right to add an addendum to such records if recorded information is disputed. By signing this consent, you agree to allow Burke Dermatology to use and disclose personal information about you for the reason above. You have the right to revoke this consent at any time but must be aware that we cannot guarantee your care unless we can communicate with other health professionals when necessary. This notice of privacy will become part of the patient's medical record.

SIGNATURE: _____ TODAY'S DATE: _____

Burke Dermatology
History & Intake Form
Please Check All That Apply

Are we authorized to leave detailed voice messages including biopsy and culture results?

- ❑ Yes
- ❑ No

Past Medical History

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation (Irregular Heartbeat)
- ❑ Benign Prostatic Hyperplasia
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDs
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ **NONE**

Other _____
_____
_____
_____
_____
_____

Past Surgical History

- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast: Biopsy
- ❑ Breast: Lumpectomy; RIGHT, LEFT, BOTH
- ❑ Breast Mastectomy; RIGHT, LEFT, BOTH
- ❑ Colon (Colectomy): Colon Cancer Resection
- ❑ Colon (Colectomy): Diverticulitis
- ❑ Colon (Colectomy): Inflammatory bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart: Biological Valve Replacement
- ❑ Heart:Coronary Artery Bypass Surgery
- ❑ Heart: Heart Transplant
- ❑ Heart:Mechanical Valve Replacement
- ❑ Heart:PTCA
- ❑ Joint Replacement Hip; RIGHT, LEFT, BOTH
- ❑ Joint Replacement Knee; RIGHT, LEFT, BOTH
- ❑ Kidney: Biopsy, Stone Removal, Transplant
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries Oophorectomy: Endometriosis
- ❑ Ovaries Oophorectomy: Cyst
- ❑ Ovaries Oophorectomy: Ovarian Cancer
- ❑ Ovaries Oophorectomy: Prostate Cancer
- ❑ Ovaries: Tubal Ligation
- ❑ Rectum: APR
- ❑ Rectum: Lower Anterior Resection
- ❑ TURP
- ❑ Testicles (Orchiectomy)
- ❑ MOHs Skin Cancer surgery
- ❑ Uterus: Fibroids
- ❑ Uterus: Uterine Cancer
- ❑ Uterus: Cervical Cancer
- ❑ **NONE**

Skin Disease History

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Basal cell skin cancer
- ❑ Blistering sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itching Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous cell skin cancer
- ❑ **NONE**

Other:_____

_____

Do you tan in a tanning salon?
Yes _____ No ___

Do you wear sunscreen?

- ❑ Yes If Yes, what SPF?___
- ❑ No

Family History
(Which Member) M/Mother F/Father S/Sister B/Brother U/Uncle A/Aunt GM/Grandmother GF/Grandfather

- ❑ **Melanoma**
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Asthma
- ❑ Seizures
- ❑ Malignancy Type_____
- ❑ Angina
- ❑ Respiratory Disease
- ❑ Breast Cancer
- ❑ Stroke
- ❑ Eczema
- ❑ Allergies
- ❑ Glaucoma
- ❑ **NONE**

Alerts

- ❑ HIV Positive
- ❑ Latex Allergy
- ❑ Currently Pregnant or planning pregnancy
- ❑ Breastfeeding
- ❑ Becomes faint or dizzy with surgical procedures
- ❑ Blood thinners
- ❑ Pacemaker
- ❑ Defibrillator
- ❑ History of MRSA
- ❑ Allergic to Sulfa Drugs or Sulfa creams
- ❑ Allergies to adhesives
- ❑ Allergy to topical Antibiotic
- ❑ Rapid Heartbeat with Epinephrine
- ❑ Allergy to Lidocaine
- ❑ Yeast infections with antibiotics
- ❑ GI upset with antibiotics
- ❑ Active/ History of Hepatitis
- ❑ West Africa: Travel or contact
- ❑ **NONE**

Smoking Status

- ❑ Never Smoker
- ❑ Daily Smoker
- ❑ Former Smoker

Pneumonia Vaccine (If over 65 years old)

- ❑ Yes
- ❑ No

Medications: MUST INCLUDE **DOSING** AND **FREQUENCY** DUE TO INSURANCE PURPOSES

- ❑ **NONE**

_____

_____

_____

_____

Drug Allergies:

- ❑ **NKDA (NO KNOWN DRUG ALLERGIES)**

_____

_____

_____