PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:_____ REFERRED BY:_____ SEX:_____

NAME:_____ BIRTHDATE:_____
LAST FIRST MIDDLE

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE:_____ CELL PHONE:_____ WORK NUMBER:_____

SS #_____ MARITAL STATUS:_____ EMAIL:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

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RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:_____

****

NEXT OF KIN:_____ BIRTHDATE:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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EMERGENCY CONTACT:_____

ADDRESS IF DIFFERENT:_____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:_____ MALE_____ FEMALE_____ TELEPHONE:_____

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RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

SS #:_____ BIRTHDATE_____ TELEPHONE:_____

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PRIMARY INSURANCE:_____ ID#:_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

SECONDARY INSURANCE:_____ ID#_____ GROUP#_____

NAME OF INSURED:_____ INSURED'S BIRTHDATE:_____

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

SIGNATURE:_____ DATE:_____

Steven A. Smith, MD
Dermatology

104 Lone Oak Circle
Fort Gibson, OK 74434

PATIENT INFORMATION (Please complete this section): **(All Information Confidential)**

Name_____ Birthdate _____/_____/_____ Age_____

Reason for visit today_____ Referred by_____

SURGICAL HISTORY	
Date	Type of Surgery

SOCIAL HISTORY		
Check (✓) if your work exposes you to the following.	Check (✓) which substances you use and indicate how much you use per day/week.	
Hazardous substances Other	Caffeine Tobacco	Drugs Alcohol

PROBLEM LIST Check (✓) if you have had or currently have any of the following.		If none, check here: ☐
☐ Fever or Chills	☐ Irritation of Eyes	☐ Joint Aches
☐ Night Sweats	☐ Tearing of Eyes	☐ Muscle Weakness
☐ Weight Loss (unintentional)	☐ Other Eye Problems	☐ Neck Stiffness
☐ Headaches	☐ Artificial Heart Valve	☐ Diabetes
☐ Seizures	☐ Chest Pain	☐ Thyroid Problems
☐ Stroke	☐ Defibrillator	☐ Bleeding Disorder
☐ Anxiety	☐ Heart Disease	☐ Problems with Bleeding
☐ Depression	☐ High Blood Pressure	☐ Allergy to Latex
☐ Changing Moles or New Moles	☐ Pacemaker	☐ Allergy to Lidocaine/Epinephrine
☐ Connective Tissue Disease	☐ Cough	☐ Allergy to Topical Antibiotic Ointments
☐ Herpes Simplex (Fever Blisters)	☐ Shortness of Breath	☐ Antibiotics Prior to Procedures
☐ New Rash or Rashes	☐ Wheezing	☐ Hay Fever
☐ Problems with Scarring (Hypertrophic or Keloid)	☐ Abdominal Pain	☐ Reaction to Coumadin, Plavix, Pradaxa or Aspirin
☐ Problems with Healing	☐ Bloody Stool	☐ Cancer
☐ Blurry Vision	☐ GI Upset with Antibiotics	☐ Hepatitis
☐ Sore Throat	☐ Stomach Ulcers	☐ HIV/AIDS
☐ Cataracts	☐ Bloody Urine	☐ Immunosuppression
☐ Dryness of Eyes	☐ Yeast Infections with Antibiotics	☐ Pregnant or Nursing
☐ Glaucoma	☐ Artificial Joints	☐ Other

Check (✓) if your blood relatives had any of the following and indicate the relationship to you.		
☐ Skin Cancer/Routine _____	☐ Psoriasis _____	☐ Lupus _____
☐ Skin Cancer/Melanoma _____	☐ Eczema/Atopic Dermatitis _____	☐ MRSA _____
☐ Skin Cancer/Death _____	☐ Asthma _____	☐ Tuberculosis _____

Anything else you feel the doctor needs to know?_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to examination/treatment/surgery if indicated by the physicians of Tahlequah City Hospital.

Signature:_____ Date:_____

Reviewed by:_____ Date:_____

MEDICATION SUMMARY

PATIENT _____ DOB _____/_____/_____

PHARMACY _____PHARMACY PHONE # _____

ALLERGIES _____

_____

START DATE	MEDICATION/STRENGTH	DIRECTIONS	PRESCRIBED BY