CENTRAL FLORIDA DERMATOLOGY ASSOCIATES, P.A.

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone: _____

Any restrictions for contacting you? ☐ No ☐ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Sex: Female

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

Policy Holder: _____ DOB: _____ Patient Relationship to the Policy Holder: _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Policy Holder: _____ DOB: _____ Patient Relationship to the Policy Holder: _____

Physician/Pharmacy Information

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone _____

Location: _____
Street Address City/State/Zip

I understand that office visit charges are payable on the day service is rendered. I authorize Central Florida Dermatology Associates to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Central Florida Dermatology Associates and myself.

Signature _____ **Date** _____

PATIENT MEDICAL HISTORY

Central Florida DERMATOLOGY ASSOCIATES

KATHLEEN W. JUDGE, M.D.
MEDICAL DIRECTOR
DIPLOMATE OF THE AMERICAN BOARD OF DERMATOLOGY
DERMATOLOGY AND DERMATOLOGICAL SURGERY

PLEASE CIRCLE ALL THAT APPLY:

Bronchitis	Pacemaker	Kidney Transplant		Arthritis
COPD/ Emphysema	Heart Transplant	Dialysis		Bladder Problems
Asthma	Heart Valve Replacement	Seizures		Intestinal Problems
Tuberculosis	Diabetes	Stroke		Joint Replacement
Lung Cancer	Liver Disease	Bleeding Disorder		Reproductive Tract
Sarcoidosis	Liver Transplant	Thyroid Disease		Prostate Disease/Cancer
High Blood Pressure	Hepatitis	Depression		
Heart Disease	Kidney Disease	Stomach Ulcers		

List any **other diseases or conditions:** _____

List all **medications** (oral, injection, topical, prescription, over the counter, and herbal): _____

_____

List all previous **surgical procedures:** _____

List all **allergies:** _____

SKIN HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Have you ever had skin cancer?	YES	NO	_____
Family history of skin cancer?	YES	NO	_____
Do you have a history of skin diseases?	YES	NO	_____
Do you have any problems healing?	YES	NO	
Do you develop keloid/raised scars after surgery?	YES	NO	
Do you bleed easily?	YES	NO	

When exposed to sun, do you: Tan Tan & Burn Burn

SOCIAL HISTORY

Do you smoke? YES NO If yes, how many packs per day? _____

Do you drink alcohol? YES NO If yes, how many drinks per day? _____

Are you pregnant? YES NO Due date: _____ Breastfeeding? YES NO

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy City, State Zip: _____

PRINT PATIENT NAME	SIGNATURE OF PATIENT/LEGAL GUARDIAN	DATE
_____	_____	_____