

**PATIENT DATA -**

Date: \_\_\_\_\_  
Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS #: \_\_\_\_\_  
Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Employer/School: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**BILLING DATA - Complete if Patient is minor or Billing address is different.**

Name: \_\_\_\_\_ SS #: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**INSURANCE DATA -**

PRIMARY INS: _____	SECONDARY INS: _____
Policy Holder: _____	Policy Holder: _____
Birthdate: _____	Birthdate: _____
Certificate/SS #: _____	Certificate/SS #: _____
Group #/Employer: _____	Group #/Employer: _____

**PARENTS OR SPOUSE:** \_\_\_\_\_ Work Phone: \_\_\_\_\_

**NEAREST RELATIVE OR FRIEND - OUTSIDE THE HOME**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**HOW DID YOU HEAR**

Referring

**ABOUT US?** \_\_\_\_\_

Dr. Name: \_\_\_\_\_

**ALLERGIES TO MEDICINES -**

**LIST ALL MEDICATION TAKEN ON A DAILY BASIS**

_____	_____
_____	_____
_____	_____
_____	_____

**MAJOR HEALTH PROBLEMS -**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize the use or disclosure of my individually identifiable health information to the following individuals. Please understand, if a family member's name is not listed below, by law, we are not able to communicate with them regarding your treatment, in any form. I understand that this authorization is voluntary and can be revoked in writing at any time.

Name

Relationship

_____	_____
_____	_____
_____	_____
_____	_____

**PATIENT CONSENT AUTHORIZATION -**

I HEREBY AUTHORIZE **AFFILIATED DERMATOLOGY & SKIN CANCER CLINICS** TO FURNISH INFORMATION TO MY INSURANCE CARRIER AND REFERRING PHYSICIAN CONCERNING MY ILLNESS AND TREATMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL AND BILLS ACCRUED BY DEPENDENTS. IF PATIENT IS A MINOR, I HAVE AUTHORITY TO AUTHORIZE TREATMENT.

**SIGNATURE** \_\_\_\_\_

**MEDICARE -**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Peter Muelleman for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
SIGNATURE

**INSURANCE DATA -**

We accept: MEDICARE assignment  
FIRSTHEALTH  
BC/BS PPO  
FREEDOM NETWORK  
FREEDOM NETWORK SELECT

**PAYMENT DATA -**

COPAYS are expected at the time of service.  
MEDICARE patients are expected to pay towards their yearly deductible - if not met.  
ALL OTHER INSURANCE: Payment is expected at the time of service.

# Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient, parent or legal guardian

If signed by patient representative, state relationship to patient

\_\_\_\_\_

REVIEW OF SYSTEMS

\*\*\*TO BE COMPLETED BY THE PATIENT\*\*\*

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

CONSTITUTIONAL SYMPTOMS

GOOD GENERAL HEALTH LATELY	YES	NO
RECENT WEIGHT CHANGE	YES	NO
FEVER	YES	NO
FATIGUE	YES	NO
HEADACHES	YES	NO

INTEGUMENTARY (SKIN)

RASH OR ITCHING	YES	NO
CHANGE IN SKIN COLOR	YES	NO
CHANGE IN HAIR OR NAILS	YES	NO
VARICOSE VEINS	YES	NO

HEMATOLOGIC/LYMPHATIC (BLOOD)

SLOW TO HEAL AFTER CUTS	YES	NO
BLEEDING OR BRUISING TENDENCY	YES	NO
ANEMIA	YES	NO
PHLEBITIS	YES	NO
PAST TRANSFUSION	YES	NO
ENLARGED GLANDS	YES	NO

ALLERGIC/IMMUNOLOGIC

HISTORY OF SKIN REACTION OR OTHER ADVERSE REACTION TO:

PENICILLIN OR OTHER ANTIBIOTIC	YES	NO
MORPHINE, DEMEROL, OTHER NARCOTIC	YES	NO
NOVACAIN OR ANESTHETIC	YES	NO
ASPIRIN OR PAIN REMEDY	YES	NO
TETANUS ANTITOXIN OR OTHER ANTISEPTIC	YES	NO
IODINE, METHIOLATE OR ANTISEPTIC	YES	NO
OTHER DRUG/MEDICATION	YES	NO
FOOD ALLERGIES	YES	NO

ADDITIONAL COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICIANS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_