Patricia C. McCormack, M.D., F.A.A.D.

Diplomate of the American Board of Dermatology

Adult & Pediatric Dermatology

www.patriciamccormackmd.com

Today's date: _____

PATIENT INFORMATION

Last name: _____ First name: _____

Date of birth: _____ Age: _____Gender **:** **M◯ F◯** Marital: **S◯ M◯W◯D◯**

Address: _____Zip Code:_____

Social Security #: _____ __Home Phone: _____

Occupation: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Insurance: _____ **Policy Holder:** _____ **DOB:** ___/___/____

Primary Care Physician / OBGYN (name & phone # & address)

Name:_____

Address:_____ Phone:_____

Your Primary Pharmacy

Name _____ Town _____ Phone# _____

Emergency Contact

Name: _____ Phone(s) _____

Address: _____

Other referral source (friend, ad, website, etc.): _____

CURRENT SKIN PROBLEMS

Please explain the reason(s) for today's visit … (skin concerns, check-up, cosmetic)_____

Site _____ For how long?_____

Severity _____ Past Treatment _____

MEDICATIONS AND MEDICATION ALLERGIES

List all of the oral and/or topical medications that you use including vitamins, herbal supplements and over-the-counter medications.

_____

_____

Allergies to medications (pill, injectable drugs, creams and lotions, etc.) _____

_____

SOCIAL HABITS

Alcohol Use: ◯Yes ◯No How much? _____ Quit? When _____
Street Drugs: ◯Yes ◯No How much? _____ Quit? When _____
Smoking: ◯Yes ◯No How much? _____ Quit? When _____

PERSONALSKIN HISTORY

Please check Y for Yes or N for No if you have or have had any of the following conditions:

Actinic Keratosis "precancer")	NO◯	YES◯	Lupus, erythematous	NO◯	YES◯
Acne	NO◯	YES◯	Psoriasis	NO◯	YES◯
Excessive hair growth	NO◯	YES◯	Pigmentary problems	NO◯	YES◯
Excessive sweating	NO◯	YES◯	Rosacea	NO◯	YES◯
Eczema or Atopic Dermatitis	NO◯	YES◯	Keloid scarring	NO◯	YES◯

Have you ever had skin cancer? ◯Yes ◯No If so, in what year _____ site _____
Please indicate type: ◯Basal Cell ◯Squamous Cell ◯Melanoma ◯Other
Have you ever had any other skin conditions? _____

OTHER PAST MEDICAL HISTORY

Do you have a history of asthma? ◯Yes ◯No
Have you had seasonal allergies or hay fever? ◯Yes ◯No
Have you ever had cold sores (Herpes Simplex Infection)? ◯Yes ◯No
For Women: Are you pregnant? ◯Yes ◯No
If you are nursing, are you breast feeding? ◯Yes ◯No
Are you using Birth Control? ◯Yes ◯No

FAMILY HISTORY

Please check Yes or No if you have a family history of any of the following conditions:

Acne	NO◯	YES◯	Rheumatoid Arthritis	NO◯	YES◯
Basal Cell Carcinoma	NO◯	YES◯	Lupus	NO◯	YES◯
Squamous Cell Carcinoma	NO◯	YES◯	Psoriasis	NO◯	YES◯
Melanoma	NO◯	YES◯	Pigmentary problems	NO◯	YES◯
Eczema	NO◯	YES◯	Rosacea	NO◯	YES◯

Other family medical history (skin conditions and/or other conditions): _____

_____

_____

_____

GENERAL MEDICAL HISTORY

Please list all previous or current medical problems, illness and major diagnoses, along with the dates thereof.

_____

_____

_____

Please list all previous surgeries and other medical procedures you have undergone, alone with the dates thereof.

_____

_____

_____

SYMPTOM REVIEW

Are you currently having problems in any of the areas below? Circle each area in which you have a problem.

Allergies	Fevers, chill, sweats	Male reproductive organs
Bleeding	Thyroid / other endocrine	Joints / Back / Neck
Breathing	Eye(s)	Neurological
Heart	Stomach	Mood/ Psychiatric
Weight loss or gain	Female reproductive organs	Ears / Nose / Throat

REVIEW OF SYSTEMS

Do you have trouble with wound healing? Yes No

Do you tend to bleed excessively? Yes No

Do you have a tendency to form hypertrophic scars and keloids? Yes No

Have you had an allergic reaction to bandages and tape? Yes No

Do you have enlarged lymph nodes? Yes No

Are you immunosuppressed, e.g. HIV/AIDS or a history of lymphoma or leukemia? Yes No

Do you have a prosthetic hip or knee joint? ◯ Yes ◯ No

Do you have a pacemaker / defibrillator? ◯ Yes ◯ No

Do you take aspirin or coumadin or other anticoagulants? ◯ Yes ◯ No

Do you have a history of blood clots or emboli? ◯ Yes ◯ No

Have you ever fainted or became light-headed during minor surgical procedures? ◯ Yes ◯ No

Would you like information on (please circle):

- ☐ Botox treatments / Fillers (Restylane, Perlane, Juvederm, Radiesse)
- ☐ Scar treatments (e.g. acne scars)
- ☐ Chemical Peels (e.g. VI Peel, glycolic acid, TCA)
- ☐ Spider and varicose vein treatment
- ☐ Laser Treatments (hair removal, rosacea, scar, birthmarks, dark spots, tattoos', acne, Rejuvenation, wrinkles)

If you have any other concerns or comments, please note them here.

_____

_____

Patient Signature: _____ Date: _____

SIGNATURE-ON-FILE AND FINANCIAL AGREEMENT

I, _____, acknowledge that Dr. Patricia C. McCormack's office will bill the insurance company about which I have provided information on the day of my visit, as a courtesy to me. However, as the patient, I am ultimately responsible for my medical bills if, for whatever reason, I become ineligible with the insurance company at the time of service, or if my insurance company denies payment for any reason for a service provided by the office from Dr. Patricia C. McCormack's office.

_____ _____

Patient Name Date

REQUEST FOR LIMIATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENT PLEASES NOTE:
This practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name: _____ **DOB** _____
Patient Address: _____
City: _____ **State**: _____ **Zip**: _____

Please mark where you **DO NOT** want us to contact you:

(If no restrictions, please check "**NO RESTRICTIONS"** and sign below)

- ☐ Home phone
- ☐ Home address
- ☐ Work Phone
- ☐ Work Address
- ☐ Spouse's work
- ☐ Email
- ☐ Other
- ☐ **NO RESTRICTIONS**

Please mark any information that may not be shared with your other physicians, pharmacy, or your insurance company:

- ☐ Occupation
- ☐ Name of employer
- ☐ Visit notes/hospital notes
- ☐ Prescription information
- ☐ Patient history
- ☐ Other _____
- ☐ **NO RESTRICTIONS _____**

****PAYMENT AND/OR CLAIM MAY BE DENIED IF CERTAIN INFORMATION IS RESTRICTED TO YOUR INSURANCE COMPANY****

Do you have any special instructions, requests or person(s) who you would like to have access to your medical conditions.

_____

_____

Person(s) Name_____

_____ _____

Signature of Patient or Legal Guardian Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED OR OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE

_____ _____

Print Name Date

_____ _____

Parent of Authorized Representative Date

_____ _____

Signature Date

Note

This acknowledgement shall remain valid for period of (6) years from date of signing.

If you would like to review, read, or take a copy of the notice of privacy practices, please ask a member of Dr. McCormack's staff.

PRINT SEND