

I authorize Albemarle Dermatology Associates to release any medical or other information necessary to process this claim and any future claims. I authorize payment of medical benefits to the provider for services rendered. I also request payment of government benefits either to myself or to the party who accepts assignment.

I understand that I am financially responsible for all charges not paid by insurance. I understand if my account becomes assigned to a collection agency, that I am responsible to pay the collection agency fee, court cost and attorney fees.

**Your copay is expected at the time of service.** If you do not pay on the day of your appointment a \$10.00 billing fee will be added to your account.

**\*\*Do we have your permission to:**

- Leave a message on your home answering machine  Yes  No
- Leave a message on your work voice mail?  Yes  No
- Discuss your medical condition with any member of your household?  Yes  No  
If yes, whom: \_\_\_\_\_ Relationship: \_\_\_\_\_
- If patient is a minor, information can be discussed with:  
 Mother  Father  Step-Mother  
 Step-father  Grandmother  Grandfather

**\*\*Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
Patient or Legal Guardian

DATE: \_\_\_\_\_

Patient's Full Name \_\_\_\_\_  
Last Name First Name Middle Initial

Your Mailing/Billing Address \_\_\_\_\_  
Street City State Zip Code

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ Marital Status M W S D

If Married, Spouse Name \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_

Insurance #1 \_\_\_\_\_ Subscriber \_\_\_\_\_ Relationship \_\_\_\_\_  
\*\*\* Subscriber Date of Birth \_\_\_\_\_

#2 \_\_\_\_\_ Subscriber \_\_\_\_\_ Relationship \_\_\_\_\_  
\*\*\* Subscriber Date of Birth \_\_\_\_\_

**MEDICAL HISTORY**

Medications: \_\_\_\_\_  
\_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Family History of Skin Cancer?  NO  YES, Type: \_\_\_\_\_ Relation: \_\_\_\_\_

Personal History of Skin Cancer?  NO  YES \_\_\_\_\_

Dermatology Medications:  NO  YES \_\_\_\_\_

Do you have any of the conditions listed below: (please check yes or no)

	YES	NO		YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Aids	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Type of Cancer _____		

SIGNATURE \_\_\_\_\_

\*\*Patient or Legal Guardian\*\*

PHYSICIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_