

Date _____

Patient Data No. _____

Patients Please Complete This Section

It is our desire to reach you in the most efficient manner so we request that you provide ACCURATE information. When providing contact information please note that appointment reminder calls are made in the evening hours two days prior to your appointment. Other calls may be made during regular business hours.

1. Best Phone Number to Reach You for Appointment Reminders (Evenings):

2. Best Phone Number to Reach You Regarding Your Medical Care (Daytime):
_____ Ext. _____

3. Alternate Phone Number:

Patient Information

Social Security# _____

Name _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Sex ____ M ____ F Marital Status _____ Race _____

Patient Employed by _____ Occupation _____

E-Mail Address _____

How did you hear about our office? _____

In case of emergency who should be notified? _____

Relationship _____ Phone _____

Is there someone other than the patient who should be contacted regarding medical care?

Name _____ Phone _____

Relationship: Caretaker/Medical POA/Other (Please Specify) _____
(Daughter, Son, Etc.)

Primary Insurance

Person Responsible for Account _____

Relation to Patient _____ Birth Date _____ Soc. Sec# _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Group # _____ Subscriber _____

Additional Insurance

Is patient covered by additional insurance? ____ Yes ____ No

Subscriber Name _____ Relationship to patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec # _____

Group # _____ Subscriber # _____

I certify that the information above is accurate and complete.

Signature _____

Date _____

CARY DERMATOLOGY CENTER, P.A.

MEDICAL HISTORY

Patient _____ Date: _____ Age _____

Referred by _____ Personal Physician _____

Reason for today's visit _____

Are you allergic to any medications? Yes No If yes, list _____

List all Medications you are currently taking: _____

Do you have now, or have you ever had diseases or conditions below: (please check YES or NO)

Lungs	YES	NO	UPDATED	Other Systemic:	YES	NO	UPDATED
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular:				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Convulsions, Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____	(Women) Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you have artificial joints(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you drink alcohol? YES NO If Yes _____ drink per day

Do you use IV drugs? YES NO If Yes, what _____ how much? _____

Do you smoke: YES NO If Yes, how much: _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Have you ever had dental anesthesia (Novacaine) YES NO Any bad reaction? YES NO

Skin:

When you are exposed to sun do you: Tan only Tan and burn Burn

Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO If YES, who? _____

Do you have a history of any specific skin diseases? YES NO

If YES, please list: _____

List any other disease or condition we should know about: _____

List any surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

What is your occupation? _____

What are your hobbies? _____

Has anyone in your family been seen in our office? YES NO

If yes, please give name and relationship _____

Completed by: Patient Parent
 Medical Assistant _____

Signed by Physician _____ Date _____

Updated _____	Updated _____	Updated _____
Initial _____	Initial _____	Initial _____
Date _____	Date _____	Date _____



CARY DERMATOLOGY CENTER, P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Cary Dermatology Center, P.A. / Your Touch at Cary Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Cary Dermatology Center, P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cary Dermatology Center, P.A. / Your Touch at Cary Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cary Dermatology Center, P.A., Attn: Catherine M. Hren, M.D., Privacy Officer at 101 S.W. Cary Parkway, Suite 210, Cary, North Carolina 27511.

With my consent, Cary Dermatology Center, P.A. / Your Touch at Cary Dermatology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Cary Dermatology Center, P.A. / Your Touch at Cary Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Cary Dermatology Center, P.A. / Your Touch at Cary Dermatology may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Cary Dermatology Center, P.A. / Your Touch at Cary Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents, or other parties listed below, unless you object.

By signing this form, I am consenting to Cary Dermatology Center, P.A./Your Touch at Cary Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Cary Dermatology Center, P.A. / Your Touch at Cary Dermatology may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

CARY DERMATOLOGY CENTER, P.A. - 101 SW CARY PARKWAY - SUITE 210 - CARY, NORTH CAROLINA 27511
PHONE: 919-467-8556 - FAX: 919-380-1480

CANCELLATIONS, MISSED APPOINTMENTS AND NO SHOWS

OUR OFFICE REQUIRES 24 HOURS NOTICE FOR ANY CANCELLATION OR CHANGE TO AN APPOINTMENT.

WE ATTEMPT TO MAKE REMINDER CALLS TWO DAYS IN ADVANCE BUT THIS IS A COURTESY AND PATIENTS ARE NOT ALWAYS REACHABLE. ONCE AN APPOINTMENT IS MADE IT IS YOUR RESPONSIBILITY TO KEEP A RECORD OF IT IN YOUR CALENDER AND NOTIFY US IF YOU NEED TO CANCEL OR CHANGE THE APPOINTMENT.

CANCELLATIONS CAN BE MADE DURING REGULAR OFFICE HOURS WITH A MEMBER OF OUR STAFF OR AFTER HOURS BY LEAVING A MESSAGE ON OUR VOICE MAIL.

IF YOU FAIL TO GIVE SUFFICIENT NOTICE A FEE OF \$25.00 WILL BE CHARGED.

THIS FEE WILL BE ASSESSED UNDER THE FOLLOWING CIRCUMSTANCES:

AN APPOINTMENT IS MISSED WITHOUT NOTIFYING OUR OFFICE (NO SHOW).

CANCELLING OR RESCHEDULING WITH LESS THAN 24 HOURS NOTICE (THE SAME DAY).

ALTHOUGH WE UNDERSTAND THAT EMERGENCIES DO OCCUR, FAILURE TO GIVE SUFFICIENT NOTICE DOES NOT ALLOW US TO PROVIDE SERVICE TO OTHERS WHO MAY NEED CARE.

