

Society Hill Dermatology
932 Pine Street
Philadelphia, PA 19107
215-829-6861

Information is Confidential

Patient Information Form

Referred by _____ Date _____

Patient's Name _____ Age _____
(last) (first) (middle)

Social Security# _____ Marital Status _____ Date of Birth _____

Address _____
(street) (city) (zip)

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email Address _____

Employer _____ Address _____

Occupation _____

Contact name and number in case of emergency:

Name _____ Number _____

Must be filled in:

Guarantor's Name _____ Date of Birth _____
(name of policy holder)

Address _____ Phone Number (____) _____

ALL CO-PAYS ARE DUE ON THE DAY OF YOUR VISIT. IF YOU DO NOT HAVE YOUR CO-PAY, YOU WILL BE ASKED TO RESCHEDULE YOUR VISIT.

Please Check Insurance carrier: _____ Keystone East _____ Aetna _____ Medicare
_____ Personal Choice _____ Blue Shield (**We do not accept Horizon or BCBS/PEBTF**)

We do not accept reimbursement from any other carrier.

In the event of an outstanding balance, your account will be forwarded to a collection agency if greater than sixty (60) days past due.

Your signature below indicates you are the responsible party for payment of all services rendered.

Date _____ Signature _____

SOCIETY HILL DERMATOLOGY

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Patient Name _____ Age _____ Date _____

Allergies: _____

Current Medications: _____

Reasons for Today's Visit (Chief Complaint) _____

Current or Past Problems with: (Review of Systems)			
	Yes	No	(If Yes, Explain)
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
General Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/Muscles/Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females: Are You Pregnant _____ Yes _____ No Planning to Become Pregnant? _____ Yes _____ No

Family History (Past Family & Social History)

Mother: Living/Deceased Age _____ Father: Living/Deceased Age _____ No. Of Children _____

Check Following Medical Conditions that Have Occurred in Your Family:			
Disease	Mother	Father	Blood Relative
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History:

Do You Live Alone? _____ Yes _____ No Occupation _____

Do You Smoke? _____ Yes _____ No Frequency _____ Hobbies/Leisure Activities _____

Do You Drink? _____ Yes _____ No Frequency _____ Reviewed _____

Do You Use _____ (MD/PA Signature)

Recreational Drugs? _____ Yes _____ No Frequency _____ Date _____ Update _____

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Cosmetic Interest Questionnaire

Patient Name: _____ Date: _____

Health issues and procedures or products of interest to you (please check all that apply).

- | | |
|--|---|
| <input type="checkbox"/> BOTOX® Cosmetic
(Botulinum Toxin Type A) | <input type="checkbox"/> Skin Care Advise |
| <input type="checkbox"/> AHA and Glycolic Peels | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Collagen Therapy | <input type="checkbox"/> Liver Spots/Age Spots |
| <input type="checkbox"/> Skin Rejuvenation | <input type="checkbox"/> Sunscreen Advice |
| <input type="checkbox"/> Avage™ Retin-A or Renova | <input type="checkbox"/> Removing Leg Veins |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Facials and Eye Treatments |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Other, please specify _____ | <input type="checkbox"/> Spider Vein Treatments |
| _____ | <input type="checkbox"/> Removing Facial Veins |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

- Approval to Send Information

Patient Signature

Thank You!

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**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I, _____ have received a copy of Society Hill Dermatology's Notice of Privacy Practices. I hereby give my consent for Society Hill Dermatology to use and disclose my healthcare information to carry out treatment, payment and healthcare operations as per the Notice of Privacy Practice.

Signature of Patient

Date

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**Patient Authorization for Use and Disclosure
of Protected Health Information**

By signing this authorization, I authorize Society Hill Dermatology to use and/or disclose certain protected health information (PHI) about me to:

Name

Address

This authorization permits Society Hill Dermatology to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

This information will be used or disclosed for the following purpose:

If requested by the patient, purpose may be listed as “at the request of the individual.”

Signed by:

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian

Witness