# MEIRSON DERMATOLOGY

PLEASE PRINT

## PATIENT INFORMATION

Last Name | First Name | Middle Initial | Home Phone # ( )

Street Address | Apt. No. | Cell Phone # ( )

City | State | Zip Code (+4) | Work Phone # ( )

Sex (M / F) | Status: Married Single Widowed (Please circle one) Minor Divorced | Date of Birth | Age:

Referred By (Dr., HMO, PPO, Yellow Pages, a patient) specify: | Email Address: | Ever been a Patient here? ☐ Yes ☐ No

Alternate / Other Out of State Address: | City, State, Zip code (+4): | Phone #

## EMPLOYMENT INFORMATION

Occupation: | Patient: Employer's Name

Address: | City, State, Zip code (+4):

## INSURED OR RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name | Home Phone # ( )

Street Address | Apt. No. | Cell Phone # ( )

City | State | Zip Code (+4) | Work Phone # ( )

Employer's Name: | Name of Spouse: | Date of Birth

Address: | City, State, Zip code (+4):

## EMERGENCY CONTACT INFORMATION

Name | Home Phone # ( )

Street Address | Apt. No. | Cell Phone # ( )

City | State | Zip Code (+4) | Work Phone # ( )

Relationship to Patient:

**WE DO NOT BILL**

**PAYMENT IS EXPECTED WHEN THE SERVICES ARE RENDERED. IF WE FILE YOUR INSURANCE CLAIM, WE MUST HAVE ALL NECESSARY INFORMATION AND PAPERS OR ELSE YOU WILL BE BILLED. THANK YOU.**

## • LIFETIME AUTHORIZATION •

I authorize the release of any medical information required by my insurance carrier(s) needed for this or any related claim. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Health Care Financing Administration or its intermediaries or carriers any information needed for this insurance claim or any related medicare claim. A copy of this authorization may be used in lieu of the original.

I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for the services as described. A copy of this authorization may be used in lieu of the original.

I, the undersigned, understand that Dan H. Meirson, M.D., P.A. has agreed to accept Medicare and/or Health Insurance for payment of my bills. By my signature below, I acknowledge and understand that I am fully responsible for a yearly deductible and co-insurance (balance after Medicare and/or Health insurance payment) which is to be paid by me to Dan H. Meirson, M.D., P.A. I understand that I will be billed for the remaining unpaid balance and I understand that I am financially responsible for any charges not covered by this authorization. A copy of this authorization may be used in lieu of the original.

I understand that any charges not covered by my insurance company will be my responsibility. Any unpaid balance forwarded to a collection agency I understand I will be responsible for all collection fees and/or attorney fees.

SIGNATURE:_____ DATE
PATIENT

SIGNATURE:_____ DATE
INSURED, GUARANTOR, OR GUARDIAN

NAME_____ DATE OF BIRTH_____

HISTORY AND INTAKE FORM

**PAST MEDICAL HISTORY – (PLEASE CIRCLE ALL THAT APPLY)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/Aids
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other _____

**PAST SURGICAL HISTORY – (PLEASE CIRCLE ALL THAT APPLY)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy Colon Cancer Resection
Colectomy Diverticulitis
Colectomy IBD
Coronary Artery Bypass
Gallbladder Removed
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed / Endometriosis
Ovaries Removed / Cyst
Ovaries Removed / Ovarian Cancer
Prostate Removed / Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Carcinoma Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy / Fibroids
Hysterectomy / Uterine Cancer
None

Other _____

Skin Disease History *(Please circle all that apply)*

| | |
|---|---|
| Acne | Hay Fever / Allergies |
| Actinic Keratosis | Melanoma |
| Asthma | Poison Ivy |
| Basal Cell Skin Cancer | Precancerous Moles |
| Blistering Sunburns | Psoriasis |
| Dry Skin | Squamous Cell Skin Cancer |
| Eczema | None |
| Flaking or Itchy Scalp | |

Other:_____

Do you wear sunscreen? Yes No (If Yes)SPF?_____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)

_____

## Any other family history (Such as: High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)***Please list below

Mother: _____

Father: _____

Sister: _____

Brother: _____

Medications *(please list all current medications)*

_____

_____

_____

Allergies *(Please enter all allergies)*

_____

_____

_____

## Social History (Please circle one)

| Cigarette Smoking | Alcohol Use | Language |
|---|---|---|
| Never Smoked | Yes | English |
| Quit Former Smoker | NO | Spanish |
| Smokes Less than Daily | | Other _____ |
| Smokes daily | | |

| Race | Ethnicity |
|---|---|
| White | Hispanic/Latino |
| Black/African American | Non-Hispanic/Latino |
| Asian | |
| American Indian or Native Alaskan | |
| Native Hawaiian / Pacific Islander | |

Pharmacy Name _____
Pharmacy Phone Number _____
Pharmacy Street Address _____
Pharmacy Zip Code_____

| How often do you exercise ? | What is your caffeine use ? |
|---|---|
| Once a day | Once a day |
| A few times a week | A few times a week |
| A few times a month | A few times a month |
| Never | Never |

Primary Care Doctor_____
Primary Care Doctor Phone Number _____
Your Email_____