Dr. Kathleen Hutton Dermatology Patient Information Record 071011

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Patient Information

Name_____
Last First MI

Home Phone_____ Cell _____

Work_____ E-Mail_____

Birth Date_____ Age_____ ☐Male ☐Female

Home Address _____

_____
City State ZIP

☐Single ☐Married ☐Divorced ☐ Widowed

Social Security Number_____

Referred to Our Office by_____

Occupation _____Employer_____

Primary Care Doctor_____

Spouse or Parent Information

Name_____

Employer Tel

Person to Call In Case of Emergency

Name _____Tel_____

Medical History

Yes No **Do you have a history of the following?**
(Please check and **circle all** that apply)

☐ ☐ **Melanoma:** Personal or Family History
☐ ☐ **Basal Cell or Squamous Cell Carcinoma**
☐ ☐ **Excessive Bleeding** from Cuts or Surgery
☐ ☐ Have you ever **fainted or almost fainted**
☐ ☐ Asthma, Hayfever, Eczema (**please circle**)
☐ ☐ Heart Disease or Irregular Heart Beats
☐ ☐ High Blood Pressure
☐ ☐ Cardiac Pacemaker or Artificial Joint
☐ ☐ Hepatitis/Liver Disease
☐ ☐ Diabetes, Kidney or Thyroid Disease
☐ ☐ HIV Infection or AIDS
☐ ☐ Do you Smoke or Use Tobacco Products

List Previous Surgeries:_____

_____

Medical History

Drug Allergies:_____

Current Medical Problems:_____

Please List Current Medication & Today's Date
or Indicate **None** if you are not taking any Medication:

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

Primary Insurance Company. Claims Mailed to:

Insurance Company Name:_____

Insured Person / Financially Responsible Party

Primary Insured Person: (Check One)

☐Patient(if patient skip this section)☐Spouse☐Parent ☐Other

Name_____
Last First MI

Employer _____ Soc Sec # _____

Home Phone _____ Work _____

Birth Date_ _____ Age _____ ☐Male ☐Female

Home Address: _____

_____
City State ZIP

Do you have **Secondary Insurance?** ☐Yes ☐No
If **YES**, **Who** Is The Primary On The Secondary Insurance?

Name_____Date of Birth_____

Consent for Exam & Treatment / Assignment of Benefits

I give my consent for examination, treatment, biopsy &/or excision, and the exchange of medical information for purposes of medical treatment & second opinions. I hereby assign all medical benefits to which I am entitled to Kathleen Hutton, MD, Inc. I understand that I am financially responsible for all charges incurred, whether or not paid by insurance. I authorize the release of any necessary medical information to my insurance carrier to process my claim. I acknowledge that I have received a copy of the Notice of Privacy Practices. I agree to be charged $25 no-show/cancellation fee if I miss an appointment without notifying the office at least 24 hours prior to my appointment.

_____ _____
Signature Date

Date & Initials of **Review and/or Update**

_____ _____
Date Initials