



DR. MELISSA KAINER ERWIN
medical & cosmetic dermatology

Follow us on Facebook and Instagram for great skin care tips and our specials! FACEBOOK: MELISSA A. KAINER ERWIN, MD
INSTAGRAM: DRMELISSAERWIN

Email Address: _____

Welcome! Thank you for choosing our practice for your skin care needs. Please complete this form. If you have any questions, please do not hesitate to ask for assistance. **Please complete all fields fully and accurately.**

Today's Date: _____ Who Referred You? _____

Name: _____ SSN: _____ DOB: _____
Last First Middle Initial

Age: _____ Sex: _____ Marital Status: _____ Drivers Lic. # _____

Mailing Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Pharmacy: _____

Patient's Employer: _____ Employer's Phone: _____

Spouse's Name: _____ Spouse's DOB: _____

IF PATIENT IS A MINOR:

Guarantor Name: _____ Relation to Patient: _____

Guarantor SSN: _____ Guarantor DOB: _____

Guarantor Address: _____
City State Zip

Guarantor Employer: _____ Employer's Phone: _____

**INSURANCE INFORMATION MUST BE COMPLETED BY THE PATIENT
(PLEASE PRESENT INSURANCE CARD & DRIVERS' LICENSE AT TIME OF CHECK-IN)**

Primary Insurance: _____ Secondary Insurance: _____

Name of Insured: _____ Name of Insured: _____

Insured ID: _____ Insured ID: _____

Group Number: _____ Group Number: _____

Relation to Patient: _____ Relation to Patient: _____

Insured's DOB: _____ Insured's DOB: _____

Insured's SSN: _____ Insured's SSN: _____

RELEASE OF INFORMATION/EMERGENCY CONTACT

Is there anyone that you authorize us to release medical record information to (including but not limited to lab/biopsy reports and billing information)? **If there is no one selected, we will only speak with the patient pertaining to medical care and account issues.**

_____ Yes _____ No If yes, name and relationship: _____

Who should we notify in case of emergency? Name/Relationship: _____ Phone No.: _____

All patient responsibility, unmet deductible, co-pay and co-insurance is required at the time of service. If your plan is not one with which the practice is contracted, payment in full is required at the time of service. We accept Visa, Mastercard, Discover, & AmEx, as well as cash and checks. The patient is responsible for any required referrals from the primary care physician.

With this signature, I authorize treatment and release of medical or other information necessary to process my insurance claim. I request payment of government or other benefits to the party accepting assignment.

Patient or Responsible Party Signature

Date



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Patient Name: _____

Date of Appointment: _____ Reason for Appointment: _____

Date of Last Flu Shot: _____ Date of Last Pneumonia Shot: _____

If Female: Pregnant? Yes No
Tubal? Yes No
Hysterectomy? Yes No

Medication Allergies: _____

Current Medications/Vitamins: _____

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lymphoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	End Stage Renal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Atrial Fibrillation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Marrow Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
BPH	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uterine Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	OTHER MEDICAL ISSUES:	
Colon Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No		
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Past Surgeries: _____

SKIN DISEASE HISTORY (PLEASE CHECK ALL THAT APPLY)

Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Actinic Keratoses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flaking or Itchy Scalp	<input type="checkbox"/> Yes <input type="checkbox"/> No	Squamous Cell Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Basal Cell Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	OTHER SKIN DISEASE HISTORY:	
Blistering Sunburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poison Ivy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dry Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Precancerous Moles	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Family History: Has anyone in your immediate family had skin cancer? Yes No

If yes, type of skin cancer: _____ Relation: _____

SOCIAL HISTORY

Do you smoke or chew tobacco? Yes No If no, have you used tobacco in the past? Yes No

If yes, frequency of current use: _____

How many alcoholic drinks do you have in a day? _____

What is your occupation? _____

What are your outdoor hobbies? _____

I acknowledge the above to be true and correct. I have received a copy of Dr. Melissa Kainer Erwin's Notice of Privacy Practices and Office Policies. By signing below, I acknowledge receipt of these Privacy Practices & Office Policies.

Signature: _____ Date: _____