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: _____ (Last / First / Middle Initial) SSN: _____ DOB: _____

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

979.543.9933 (phone) **979.543.9959 (fax)**

Please Complete Reverse Side!

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

Past Surgeries: _____

_____

_____

SKIN DISEASE HISTORY (PLEASE CHECK ALL THAT APPLY)

Acne	□ Yes □ No	Eczema	□ Yes □ No	Psoriasis	□ Yes □ No
Actinic Keratoses	□ Yes □ No	Flaking or Itchy Scalp	□ Yes □ No	Squamous Cell Skin Cancer	□ Yes □ No
Basal Cell Skin Cancer	□ Yes □ No	Melanoma	□ Yes □ No	**OTHER SKIN DISEASE HISTORY:**	
Blistering Sunburn	□ Yes □ No	Poison Ivy	□ Yes □ No		
Dry Skin	□ Yes □ No	Precancerous Moles	□ Yes □ 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: _____