ERWIN DERMATOLOGY
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 all major credit cards, as well as cash, checks and Care Credit. We do NOT verify benefits prior to anyone's appointment. You, the patient (or guarantor) are responsible for ensuring that our office has a current referral/authorization on file if one is required by your insurance plan. I acknowledge that if my insurance requires a referral/authorization and I fail to obtain a referral/authorization from my PCP, or if my insurance denies my claim due to lack of referral/authorization, that I am responsible for payment, in full, for services rendered. 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

Patient Name: _____ Date of Appointment:_____

Reason for Appointment:_____

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

Height: _____ Weight: _____ **If Female**: Pregnant? □ Yes □ No
Breastfeeding? □ Yes □ No
Tubal? □ Yes □ No
Hysterectomy? □ Yes □ No

If Age 60 or Older: Have you received your Pneumococcal (Pneumonia) Vaccine Since Turning 60? □ Yes □ No

If Age 60 or Older: Do you have a Health Care Proxy (Someone to make medical decisions for you if you are unable to do so for yourself?) □ Yes □ No

If yes, who is your Health Care Proxy? _____

Drug 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: _____