



THE MENKES CLINIC
Medical, Surgical and Cosmetic Dermatology

PATIENT INFORMATION

PLEASE PRINT (PLEASE COMPLETE ENTIRE FORM)

Date: ____/____/____

Name: _____
LAST FIRST M.I. NICKNAME

Address: _____ Home Phone: (____) _____
STREET APT #

City: _____ State: _____ Zip: _____ Work/Cell Phone: (____) _____

Email: _____ Sex: M F Birthdate: ____/____/____ Age: ____
CIRCLE ONE

Employer: _____ Social Security #: _____

Spouse Name: _____ Social Security #: _____
IF INSURANCE IS UNDER SPOUSE'S NAME

Emergency Contact: _____ Phone #: (____) _____ Marital Status: M S W D
CIRCLE ONE

HIPPA PATIENT PRIVACY	I authorize The Menkes Clinic to discuss my appointment, financial and medical data with: Name _____ Relationship _____
	I authorize The Menkes Clinic to leave personal voice messages on phone #(s): Ph # (____) _____ Ph # (____) _____
	I request Special Privacy PProtection to restrict health information disclosure (separate form) Y ___ N___

Primary Care Physician: _____ Office Phone: (____) _____

How were you referred to our office? _____

IF PATIENT IS A MINOR Parents Name _____

Work Phone Father (____) _____ Work Phone Mother (____) _____

POLICYHOLDER (Member) INSURANCE INFORMATION
PLEASE COMPLETE ALL INSURANCE INFORMATION AND PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.

Primary Insurance _____ Secondary Insurance _____
COMPLETE ONLY IF APPLICABLE

Claims Address _____ Claims Address _____

Insurance Co. Phone (____) _____ Insurance Co. Phone (____) _____
CLAIMS PHONE NUMBER CLAIMS PHONE NUMBER

Subscriber Name: _____ Subscriber Name: _____
NAME OF PERSON INSURANCE IS COVERED UNDER NAME OF PERSON INSURANCE IS COVERED UNDER

Relationship to Subscriber: _____ Relationship to Subscriber: _____

Subscriber's Birthdate: ____/____/____ Subscriber's Birthdate: ____/____/____

Subscriber ID#: _____ Subscriber ID#: _____

Group #: _____ Group #: _____



THE MENKES CLINIC
Medical, Surgical and Cosmetic Dermatology

MEDICAL HISTORY

PLEASE PRINT (PLEASE COMPLETE ENTIRE FORM)

Date: ____/____/____

Name: _____
LAST FIRST M.I. NICKNAME

Reason for visit: _____

Duration of symptoms: _____

Current treatment of skin condition: _____

Past treatments of skin condition: _____

What makes condition worse: _____

Family history of skin condition: _____

Are you allergic to any medications: Yes No If yes, please list:

1. _____ 2. _____

List all medication you are currently taking:

1. _____ 2. _____

3. _____ 4. _____

Do you have now, or have you ever had diseases or condition of: *(Choose all that apply)*

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Nose/Throat | <input type="checkbox"/> Asthma/Hayfever/Eczema | <input type="checkbox"/> Autoimmune Diseases |
| <input type="checkbox"/> Heart/Lungs | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy/Seizures _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis/Joint | |

Do you have a history of any specific skin diseases: Yes No If yes, please list:

Family history of above conditions *(Please list)*: _____

List surgical procedures you have had in the past 6 months: _____

When are you exposed to sun, do you: Tan Only Tan and Burn Burn

Do you use sunblock: Yes No

Has anyone in your family had skin cancer: Yes No If yes, who: _____

Please answer the following questions:

A: Are you taking aspirin, blood thinners or anti-inflammatory medicines: Yes No

B. Do you smoke: Yes No Of yes, how much: _____

C. (Women) Are you pregnant: Yes No Of yes, Due Date: _____

D. Do you have artificial joint(s): Yes No

 PATIENT SIGNATURE Reviewed By: _____