Medical History Form

MINARS DERMATOLOGY

*Required Information OK Reset Form

PATIENT INFORMATION (Please Print Legibly)

Today's Date _____

*Name _____
Last First M.I.

*Mailing Address _____ Apt.#

Home Phone _____ _____ FL _____
City State Zip

Cell Phone _____ Work Phone _____

SS # _____ *Date of Birth _____

Sex M☐ F☐ E-Mail _____

PRIMARY INSURANCE HOLDER (If Different From Patient)

Name _____ Date of Birth _____

PERSON RESPONSIBLE FOR THE BILL (Autofill If Same As Patient) OK

Name _____ Date of Birth _____
Last First M.I.

*Mailing Address _____ Apt.#

_____ FL _____ SS # _____
City State Zip

Home Phone _____ Cell Phone _____

In case of emergency, notify: _____ Phone _____

Primary Care Physician _____ Phone _____

How did you hear about us?

- ☐ 1 - Our website (www.minarsdermatology.com)
- ☐ 2 - Insurance website or list
- ☐ 3 - Another patient (Friend or Family) _____
- ☐ 4 - Mailing (Letter or Postcard)
- ☐ 5 - Radio
- ☐ 6 - Newspaper _____
- ☐ Referred by my Doctor (Name) _____ MD Phone # _____
- ☐ Other (Please Specify) _____

(Office Use Only) Entered by: _____

Please Turn Over →

Medical History Form

MINARS DERMATOLOGY

*(PLEASE CHECK YES OR NO)

Today's Date

HAVE YOU HAD:	YES	NO	COMMENTS
Heart Disease	☐	☐	
Hives	☐	☐	
Lung Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Blood Disorder	☐	☐	
Cancer	☐	☐	
Bowel Disease	☐	☐	
Hepatitis	☐	☐	
Diabetes	☐	☐	
HIV+	☐	☐	
Skin Cancer	☐	☐	
Do you use tobacco?	☐	☐	

List any other serious illness:

List any family skin diseases:

Are you allergic to any drugs? (Please List)

Current Medications:

Occupation:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payments of medical benefits to Minars Dermatology LLC.

Patient or Responsible Party Signature ☐ _____ **Date**

Payment is required for all services at the time they are rendered (this includes co-payments and deductibles). Failure to pay bills on time (after two statements) results in a charge for attorney's fees (30% of total) plus interest. Patients who "no-show" (i.e. fail to cancel an appointment 24hrs in advance, may be charged a "no-show" fee of up to $100 or lose their deposit).

Patient or Responsible Party Signature ☐ _____ **Date**

I have had a chance to read over the "Office Privacy Policy" (please ask for a copy or read the copies available in the waiting room).

Patient or Responsible Party Signature ☐ _____ **Date**

(Office Use Only) Entered by: _____

Please Turn Over →

Submit Print