KANSAS CITY DERMATOLOGY, P.A.

Patient Registration (*Please Print*)

Allergies to Medications________________________________Today's Date_______________

Patient's LEGAL Name: First Middle Last	Date of Birth	Age	Male Female	SS#
Race: Circle one: AM Indian Asian Black Caucasian Hispanic Native American Other	Language:	Ethnicity: Hispanic/Latino Not Hispanic/Latino--Other		
Street Address	City/State	Zip	Home Phone ( )	
Employer's Name		Work Phone ( )		
Employer's Address	City/State	Zip		
Parent/Spouse's Name: First Middle Last	Parent/Spouse Employer	Work Phone ( )		
Parent/Spouse SS#	Employer Address			
Parent/Spouse's Street Address (if different)	City /State	Zip	Home Phone ( )	
Name of Relative or Friend Not Living With You	Relationship			
Contact Street Address	City/State	Zip	Phone ( )	

Please Complete Section Below

Responsible Party Name Mr./Mrs./Ms.	Relationship to Patient		
Street Address	City/State	Zip	Home Phone ( )
Employer's Name	Address	Phone ( )	

PRIMARY INSURANCE

Insurance Name________________________________
Insurance Member #______________________________
Insurance Group # ______________________________
Insurance Claim Address__________________________
____
Policy Holder's SS#______________________________
Policy Holder's Name_____________________________
Policy Holder's Address___________________________
____
Policy Holder's Sex M F
Policy Holder's Date of Birth______________________
Policy Holder's Employer's Name___________________
Relationship to Patient___________________________

SECONDARY INSURANCE

Insurance Name________________________________
Insurance Member #______________________________
Insurance Group#_______________________________
insurance Claim Address__________________________
____
Policy Holder's SS#______________________________
Policy Holder's Name_____________________________
Policy Holder's Address___________________________
____
Policy Holder's Sex M F
Policy Holder's Date of Birth______________________
Policy Holder's Employer's Name___________________
Relationship to Patient___________________________

Referring Information

How did you find out about our practice?____
Name Address Phone

Referring Doctor____
Name Address Phone

PCP/Family Doctor's Full Name____
Name Address Phone

I, hereby, authorize Kansas City Dermatology, P.A. to receive direct payment from insurance, release any information acquired in course of treatment/examination to my insurance for billing purposes. I am fully responsible for any amounts not paid by my insurance company.

Signed____Date__________________

KANSAS CITY DERMATOLOGY, P.A.

Patient's Request for Special Communication

Patient Name_______________________________DOB:________ Account #___________

I request that communication regarding my protected health information that is provided to me, other than verbally and in person, be provided to me by sending or calling the information to :
Address:______________________Apt #____City:____________State:____Zip:________
May we mail correspondence to this address? ☐ Yes ☐No
Home Phone # __________________ A message can be left at this number ☐Yes ☐No
Work Phone # __________________ A message can be left at this number ☐Yes ☐No
Cell Phone # ___________________ A message can be left at this number ☐Yes ☐No
Email Address ____

Yes, Kansas City Dermatology, P.A. may use this ***email*** address to inform me of health-related benefits or services that may be of interest to me.

My information may also be told to the following individuals:

Name ________________________________Relationship_______________
Address ____
Phone #____

Name ________________________________Relationship_______________
Address ____
Phone#____

This request will be kept in place at all times until I revoke this request at any time in writing and submitting such request to Kansas City Dermatology, P.A.

____
Signature

____
Signature of Personal Representative of Patient

____
Description of Representative's Authority to Act for Patient

____
Date

ON___________I RECEIVED KANSAS CITY DERMATOLOGY, P.A. NOTICE OF PRIVACY PRACTICES

_________________________ **DATE___________**
Patient Signature

KANSAS CITY DERMATOLOGY, P.A.
HEALTH HISTORY FORM

Today's Date________________________

Last Name____________________________ First Name____________________________ Date of Birth___________

Do you or have you ever had these diseases or conditions (please, check Yes or No)

RESPIRATORY:

Condition	YES	NO
Bronchitis	YES □	NO □
Emphysema	YES □	NO □
Asthma	YES □	NO □
Chronic Cough	YES □	NO □
Shortness of Breath	YES □	NO □
Wheezing	YES □	NO □
Other____________________		

CARDIOVASCULAR

Condition	YES	NO
High Blood Pressure	YES □	NO □
Chest Pain	YES □	NO □
Heart Attack	YES □	NO □
Arrhythmia	YES □	NO □
Phlebitis	YES □	NO □
Hardening of the Arteries	YES □	NO □
Artificial Valve	YES □	NO □
Pacemaker/Defibulator	YES □	NO □
Feel light headed/pass out	YES □	NO □
Feel faint with procedures	YES □	NO □
Other__________________	YES □	NO □

IMPLANTS

Condition	YES	NO
Cochlear Implant	YES □	NO □
Bladder Stimulator	YES □	NO □
Brain Stimulator	YES □	NO □
Implant any type	YES □	NO □
Other__________________	YES □	NO □

OTHER SYSTEMIC:

Condition	YES	NO
Hepatitis	YES □	NO □
Diabetes	YES □	NO □
Thyroid Problems	YES □	NO □
Kidney Disease	YES □	NO □
Dialysis	YES □	NO □
Bladder Problems	YES □	NO □
Arthritis/Joint Deformity	YES □	NO □
Artificial Joint	YES □	NO □
Convulsions	YES □	NO □
Epilepsy, Seizures	YES □	NO □
Fainting	YES □	NO □
Depression/Anxiety	YES □	NO □
HIV	YES □	NO □

GASTOINTESTIONAL

Condition	YES	NO
Stomach disorders	YES □	NO □
Nausea, Vomiting, Diarrhea	YES □	NO □
Trouble taking antibiotics	YES □	NO □
Ulcerative colitis	YES □	NO □
Crohn's disease	YES □	NO □
Yeast infection when taking antibiotics	YES □	NO □

ALLERGY

Condition	YES	NO
To adhesives	YES □	NO □
Latex	YES □	NO □
Get Hives	YES □	NO □
Antibiotic Ointment	YES □	NO □

List any other diseases or conditions____

List surgeries:____

____

List your MEDICATIONS or provide list (include Over The Counter and Herbal Medications

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

________ Do you give us permission to collect information from any pharmacy or your insurance company regarding any or all of your prescription drug history?
(Initial)

List your medication ALLERGIES and your reaction to them:

____ ____
____ ____
____ ____
____ ____
____ ____

SKIN:

Have you had skin cancer? YES □ NO □
If yes, what kind and when:____
____
History of skin disease YES □ NO □
If yes, what kind and when: ____
____
Do you have a history of abnormal moles: YES □ NO □

Family History of skin cancer? YES □ NO □ Do you have problems healing? YES □ NO □
Do you get Keloid/Thick scars? YES □ NO □ Do you bleed easily? YES □ NO □
Skin "pre" cancers ("AKs") YES □ NO □ Psoriasis? YES □ NO □
Seasonal Allergies? YES □ NO □ Eczema? YES □ NO □
Do you get rashes from: Food □ Medication □ Environment □ Ointments □ Other □ ____________
Do you take blood thinners?____ Name________________________

FAMILY HISTORY:

Have any of your blood relatives ever had skin cancer? YES □ NO □ _________________________________
If yes, what kind:____
Have any of your relatives died of skin cancer or a skin related illness? YES □ NO □ ________________________
Have any of your relatives had any type of cancer? YES □ NO □ What type: ________________________________
Do any of your relatives have a skin condition or disease? YES □ NO □ __________________________________

SOCIAL HISTORY: Do you drink alcohol YES □ NO □ How many per day___________ per week_______________
Marital Status____________________________ # of Children_____________________
Occupation_____________________________ Hobbies_______________________________________

TOBACCO USE: □ Former smoker (how much) ________ < 10 per day_________________ > 10 per day
□ Current some days smoker (how much) ________< 10 per day________ > 10 per day
□ Current everyday smoker (how much)__________< 10 per day__________> 10 per day
□ Never Smoked

Women) Are you pregnant? YES □ NO □ Due Date:________/______/__________ Breastfeeding YES □ NO □

____ Date_________________________
Patient Signature

____ Date_________________________
Provider Signature