DERMATOLOGY & SURGERY OF SOUTHERN OHIO, INC.
SCOTT C. GREVEY, M.D.
PATIENT INFORMATION

Last Name First Name M.I. Referring Physician (Last Name, First Name)

Street Address City State Zip Home Phone Number

Email Date of Birth Age Sex Marital Status Employer Phone Number

Employer Emergency Contact and Phone Number Patient Cell Phone

If patient is under 18, please print your name and relationship to the patient_____

INSURANCE INFORMATION

Primary Insurance Subscriber's DOB Employer Relationship to Patient

Subscriber's Name Subscriber's Address (if different than the patient's)

Secondary Insurance Subscriber's DOB Employer Relationship to Patient

Subscriber's Name Subscriber's Address (if different than the patient's)

Third Insurance

May we leave any and all personal medical information on your answering machine? _____Yes _____No

May we discuss any and all personal medical information with family members? _____Yes _____No

If yes, please list the names and relationship: _____

_____

The undersigned is authorizing the Assignment of Benefits. Additionally, the undersigned allows this office to release medical information to the above listed insurance carrier(s) and to accept payment for services directly from them when possible. The undersigned agrees to be financially responsible for all charges incurred and not paid by their insurance company. Checks which cannot be processed due to insufficient funds will be subject to a $25 charge. Appointments not cancelled prior to 24 hours occur a $40 charge. The signature below is acknowledgment that you have received the Notice of our Privacy Practices, HIPAA.

Signature of Patient/Responsible Party Date

Name: _____ **Date of Birth:** _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Blood Clots: Legs Lungs
Bone Marrow Transplantation
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lymphoma
Radiation Treatment
Seizures
Stroke

NONE

Cancer: Type(s)-_____

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Organ Transplant: Type-_____
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Ovaries Removed
Prostate Removed
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of: Melanoma Basal Cell Carcinoma
Squamous Cell Carcinoma Unknown Skin Cancer
If yes, which relative(s)?

_____

Medications: (Please enter all current medications)

_____

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker
Frequency: _____

Alcohol Use:
None
Frequency:_____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?