

SHIDELER

DERMATOLOGY AND SKIN CARE CENTER

www.shideler.com

Medical History

Patient's Name:	Date:
Name of Primary Care Physician:	Did a doctor recommend our office?
What is your occupation?	
What is the main reason for today's visit?	
Where is problem located?	
How long have you had the problem?	
What symptoms have you had?	
What treatments have you tried?	
Have you seen another physician for this problem?	Who?
What other problems or issues should we address during your visit?	
Please list any allergies:	
Please list all medications: (Rx, OTC, aspirin, herbals, etc.)	
What other medical problems do you have?	
What, if any, medical problems that run in your family?	
What surgical procedures have you had?	
Women Only: Are you pregnant or planning pregnancy?	Do you have a period? <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> None
Are you currently breast feeding?	What birth control?

Review of Systems: Do you have now or have recently had any of these problems – Please check Yes or No.

General: Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal: Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes: Visual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin: Growing or changing lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No
ENT: Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuro: Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory: Short of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psych: Depression or anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
GI: Stomach or intestinal discomfort	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine: Excess thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
GU: Difficulty urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No	CV: Chest pain or ankle swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lymph/Heme: Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy: Seasonal problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Past Medical/Family/Social History:

Have you had skin cancer or pre-cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have problems – poor healing or scars?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone in your family had skin cancer? _____ Type? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you prone to fever blisters or cold sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a personal or family history of any specific skin disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or family members have asthma, allergies or skin eczema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any artificial joints, heart valves, pacemaker or defibrillator?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on aspirin or blood thinners?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have thyroid problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you chew tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Smoking Status: Current Smoke daily Smoke some days/occasionally Former smoker Never smoked

755 W Carmel Drive Suite 101

Carmel, TN 46032

317 846-2396

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(Please complete using **BLACK** ink)

Patient Name: _____
Last First MI

Address: _____ City: _____ State: _____

Zip: _____ E-mail: _____

Shideler Dermatology will send out a quarterly newsletter dedicated to the care and health of your skin. We may also send information about new procedures. If you would like to receive this information, please list your email address

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Soc Sec #: _____ Sex M/F _____ Married Status _____

Race: American Indian or Alaska Native Asian Black or African American More than one race

Native Hawaiian Other Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Language: English Spanish Other _____

I authorize SDG to call and leave voicemail or a message with a family member or on my answering machine reminding me of future appointments.

Signature: _____ Date: _____

Responsible Party Information (If different from above patient or a minor):

Guarantor: _____ Relationship to Patient: _____
(Person Responsible for bill)

Guarantor's Address: _____ Zip Code: _____
(If different from Patient)

Guarantor's Home Phone: _____ Work Phone: _____
(If different from Patient)

Guarantor's Date of Birth: _____ Guarantor's Soc Sec #: _____

Please present insurance card to receptionist

Insurance Carrier: _____ ID#: _____ Group #: _____

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Soc Sec # (if not ID#) _____

Employer: _____ Employer's Address: _____

Employer Phone # _____

I understand that I am financially responsible for all charges for services rendered to me, including the balance after payment of possible insurance benefits. Our staff does file all insurances for any medical services (when complete information is received). Primary and secondary carrier claim will be submitted, on my behalf. Resubmissions of claims are only done IF we must supply additional information; otherwise all appeals are patient responsibility. I authorize payment of insurance benefits to The Shideler Dermatology and Skin Care Center. I agree to pay for all costs involved in pursuing collection of the balance due, including court cost, attorney's fees, and collection fees. I authorize the release of any medical information necessary to process a claim to my insurance carrier.

Signature: _____ Date: _____

How did you hear about our office?

Yellow pages Internet Shideler.com Family/Friend Other _____

Referring Physician Name: _____ Phone Number: _____

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