

Medical History Form



PATIENT INFORMATION (Please Print Legibly)

Today's Date _____

Name _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone () _____

Cell Phone () _____ **Work Phone** () _____

SS # _____

Date of Birth ____/____/____ **Marital Status** _____

Sex M / F **E-Mail** _____

PRIMARY INSURANCE HOLDER (If Different From Patient)

Name _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone () _____ **Work Phone** () _____

SS # _____ **Date of Birth** ____/____/____ **Sex** M / F

In case of emergency, notify: _____ **Phone** _____

Primary Care Physician _____ **Phone** _____

How did you hear about us?

- 1 - Attended a Lecture
- 2 - Yellow Pages (Hollywood)
- 3 - Yellow Pages (Ft. Lauderdale)
- 31 - Yellow Pages (Miami)
- 4 - Our website (www.minarsdermatology.com)
- 5 - Insurance List or Website
- 6 - Another patient (Friend or Family) _____
- 7 - Mailing (Letter or Postcard)
- 8 - Radio
- 81 - Television
- 9 - Newspaper _____

Referred by my Doctor (Name) _____ **MD Phone #** _____

Other (Please Specify) _____

(Office Use Only) Entered by: _____

Please Turn Over →

Medical History Form



Today's Date _____

(PLEASE CHECK YES OR NO)

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

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 Drs. Minars and/or Clark-Loeser.

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 (i.e. after two statements) results in a 30% late fee PLUS interest. We accept payment in the form of cash, check, or credit card. Patients who "no-show" (i.e. fail to cancel a scheduled appointment 24hrs in advance, may be charged a "no-show" fee, not to exceed \$75). Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ **Date** ____/____/____

I have had a chance to read over the "Office Privacy Policy" (please click here for a copy).

Patient or Responsible Party Signature _____ **Date** ____/____/____

(Office Use Only) Entered by: _____

Please Turn Over →