BELLE MEADE DERMATOLOGY
Laser & Aesthetic Center

MRN#_____ Today's Date____/____/____

PATIENT INFORMATION

(Please Print) Name _____ (_____)
Last *First* *M.* *Nickname*

SS#_____ - ____ - _____ Date of Birth ____/____/____ Age____ Gender ☐M ☐F Marital Status _____

Spouse Name _____ Date of Birth ____/____/____

Home (Billing) Address _____

City_____ State_____ Zip_____

Primary Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Your Employer _____ Work Phone (_____) _____ - _____

Spouse's Employer _____ Work Phone (_____) _____ - _____

Person Financially Responsible for this Account: _____ Relation to patient _____

Responsible Party's Birthdate _____ Address _____Phone _____

Please check whom you are seeing:

☐ Chris C. Pardue, M.D. ☐ T. Wayne Day, M.D. ☐ K. Dawn Vincent, M.D.
☐ Margaret Morgan, N.P. ☐ Kalyn Crosby, N.P. ☐ Dina Gluck, N.P.

PLEASE COMPLETE POLICY HOLDER INSURANCE INFORMATION:

Primary Insurance Company _____
Name of Policy Holder _____
Policy Holder's SS# _____
Policy Holder's Date of Birth _____
Relationship of patient to the insured_____
Address (If Different) _____
Phone (If Different)_____

Secondary Insurance Company _____
Name of Policy Holder _____
Policy Holder's SS# _____
Policy Holder's Date of Birth _____
Relationship of patient to the insured_____
Address (If Different) _____
Phone (If Different)_____

Preferred Pharmacy_____ Phone (_____) _____ - _____

Primary Care Physician _____ Phone (_____) _____ - _____

I may be contacted by the clinic at (check all that apply): ☐home ☐cell ☐work

Messages regarding health information may be left on an answering machine? ☐yes ☐no

Would you like an appointment reminder (☐yes ☐no) sent to you by: phone (_____) _____ - _____
or
text (_____) _____ - _____

In case of an emergency, who should be notified? _____Phone (_____) _____ - _____

How did you hear about us? _____

CONTINUED ON REVERSE SIDE

MEDICAL HISTORY

— check all that apply —

☐ psoriasis	☐ eczema	☐ lupus	☐ high blood pressure
☐ **diabetes**	☐ heart attack	☐ stroke	☐ irregular heart beat
☐ seizures	☐ thyroid	☐ liver	☐ blood clot
☐ anemia	☐ HIV	☐ tuberculosis	☐ **heart valve replacement**
☐ **joint replacement**	☐ pacemaker/defibrillator	☐ cataracts/glaucoma	☐ heart murmur
☐ arthritis	☐ gastrointestinal disorder		

Skin cancer? ☐ yes ☐ no Indicate type: ☐ basal cell carcinoma ☐ squamous cell carcinoma ☐ melanoma

Do you have a history of atypical moles? ☐ yes ☐ no

Cancer other than skin cancer? ☐ yes ☐ no If yes, what type? _____

FEMALES ONLY

Are you currently pregnant? ☐ yes ☐ no Currently breastfeeding? ☐ yes ☐ no

CURRENT MEDICATIONS: (including over the counter)

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Are you on any blood thinners? If yes, what are you taking? _____

MEDICATION ALLERGIES: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____ 7. _____

SOCIAL HISTORY:

Do you drink alcohol? ☐ yes ☐ no

Do you smoke? ☐ yes ☐ no

Receipt of Notice of Privacy Practices:

A copy of the Belle Meade Dermatology Notice of Privacy Practices has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

☐ I have read, understand and acknowledge the Privacy Practices of Belle Meade Dermatology.
☐ I have elected not to read the Privacy Practices of Belle Meade Dermatology.
☐ A copy of Belle Meade Dermatology's Privacy Practices was given to me today.

I hereby authorize the following person(s) to have access to my financial and medical records.

1. _____ relation to patient _____

2. _____ relation to patient _____

3. _____ relation to patient _____

I hereby authorize consent to Belle Meade Dermatology for treatment, release of medical information necessary to process claims, and for general health care operations. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I am responsible for non-covered services, co-pays, deductible, and co-insurance cost. I understand interest charges may incur after 90 days of being my responsibility at 1.5%. I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collections, I will be responsible for paying a collection fee. It is my responsibility to advise this office of any changes to my personal information at the time of service.

_____ _____

Signature of patient, or parent, or responsible party Date