Patient Demographic Information

Name you go by (first, middle, and last): ____

Legal name, *if different (for insurance & billing purposes)*: ____________________________________

Street Address: ______________________ City/State: ______________ Zip: ________

Home #: (_____) _____ - _______ Work #: (_____) _____ - _______ Cell Phone #: (_____) _____ - _______

Email Address: ______________________ How did you hear about us? ______________

Preferred Contact Method: ☐ Home ☐ Work ☐ Cell ☐ E-Mail ☐ Text Can we leave a message? ☐ H ☐ C ☐ W

Appointment reminders are via text message only. Would you like a text reminder? ☐ Yes ☐ No

Date of Birth: ____ / ____ / _______ Gender: ______________ SSN#: ______________

Does your sex assigned at birth and/or your legal sex/gender differ from the gender you listed above? ☐ Yes ☐ No

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Not listed (please specify): ____________ ☐ Prefer not to answer

Ethnicity:	**Race:**		**Preferred Language:**
☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Refuse to answer	☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other: ____________ ☐ Refuse to answer	☐ English ☐ Spanish ☐ Other: ____________

***Meaningful Use is the name of a new nationwide initiative to improve the health of our nation. As part of this initiative, Mona Dermatology is required to gather information for compliance with the Meaningful Use guideline. Part of this information includes adding patients' race, ethnicity, and preferred language to our electronic medical record. The government requires we gather this information to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a national level. If you have additional questions please visit the office of the national coordinator for health information technology at www.healthit.hhs.gov and search meaningful use.*

Insurance Information

Primary Insurance Name: ____________________ Subscriber ID: ____________ Group #: ____________
Policy Holder Name: ______________________ Date of Birth: ____ / ____ / _______ SSN#: ____________
Relationship to Insured: ______________________

Secondary Insurance Name: __________________ Subscriber ID: ____________ Group #: ____________
Policy Holder Name: ______________________ Date of Birth: ____ / ____ / _______ SSN#: ____________
Relationship to Insured: ______________________

Patients' Employment Information

Occupation: ______________________ Company/School Name: ______________________

Address: ______________________ City/State: ______________ Zip Code: ________

Patients' Emergency Contact

First/Last Name: __________________ Relationship to Patient: ____________ Phone #: (_____) _____ - _______

Family Physician:

Name: ____ Phone #: (_____) _____ - _________

Street Address: __________________________ City/State: _________________ Zip: __________

Pharmacy Information:

Pharmacy Name: _______________________________________ Phone #: (_____) _____ - _________

Communication Preferences:

I give consent to Mona Dermatology to call the following numbers listed above for non-telemarketing purposes such as appointment reminders, appointment recall messages, and any billing related issues regarding my account.

□ Home □ Work □ Cell *(including text)* □ E-Mail □ I do not consent

I give consent to Mona Dermatology to contact me for educational events and promotions.

□ Home □ Work □ Cell *(including text)* □ E-Mail □ I do not consent

______________________________ ______________________________ ___ / ___ / _____

Patient or Patient Representative (Print) Patient or Patient Representative (Signature) Date

***As of October 16, 2013 the Federal Communications Commission (FCC) has made amendments under the Telephone Consumer Protection Act (TCPA) of 1991, requiring us to have written consent for all auto-dialed & pre-recorded telemarketing and non-telemarketing calls to emergency lines, healthcare facilities, cell phones including text messaging and land lines.*

Health History:

Height: ___________ Weight: ___________

Do you drink alcohol? □ Yes □ No Do you or have you ever smoked? □ Yes □ No

Do you or have you ever used illicit drugs? □ Yes □ No

Are you allergic to any medications? □ Yes □ No If yes, please list with any reactions: ____________________

____

Please list any medications you are currently taking, with any reactions: ______________________________

____

____

Please list all over the counter medications: ____

____

Past surgeries with approximate dates: ____

____

Please check if you or any family member has had any of the following:

	Self	Mother	Father	Grand-parent		Self	Mother	Father	Grand-parent
Allergies (hay fever)	☐	☐	☐	☐	Hepatitis/jaundice	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	HIV/AIDS	☐	☐	☐	☐
Bladder Disease	☐	☐	☐	☐	Hyperthyroid	☐	☐	☐	☐
Bleeding tendency	☐	☐	☐	☐	Hypothyroid	☐	☐	☐	☐
Bowel Disorder	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	Leukemia	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐	Lupus/autoimmune dz	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Lymphoma	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	Melanoma	☐	☐	☐	☐
Cirrhosis	☐	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Neurological disorder	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	Rheumatic fever	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	Sexually transmitted dz	☐	☐	☐	☐
Gallbladder Dz	☐	☐	☐	☐	Skin Cancer	☐	☐	☐	☐
Gerd-reflux	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	Varicose veins	☐	☐	☐	☐

I certify that this information is true, correct, and complete to the best of my knowledge.

________________________________ ________________________________ ____ / ____ / ______

Patient or Patient Representative (Print) Patient or Patient Representative (Signature) Date