Swofford Dermatology Center

2101 Jackson St., Suite 205, Anderson, IN 46016
Phone 765-683-3160 • Fax 765-646-8367

Patient Information Form

Name: _____ **Birth Date:** _____

Primary Care Physician: _____

Allergies to Medications: None 1. _____ Reaction: _____
2. _____ Reaction: _____

Current Medications: None ☐ See Attached List

1. _____ 4. _____ 7. _____ 10. _____
2. _____ 5. _____ 8. _____ 11. _____
3. _____ 6. _____ 9. _____ 12. _____

Do you take the following:	Yes	No
Aspirin daily	☐	☐
Aspirin as needed	☐	☐
Coumadin or other blood thinners	☐	☐

Women of Child Bearing Age

Form of Contraception: _____

Past Medical History/Review of Systems
(Current or past problems with)

	Yes	No		Yes	No		Yes	No
Blood/Bleeding Disorders	☐	☐	History of depression	☐	☐	Gastrointestinal Disease	☐	☐
Heart Disease	☐	☐	Arthritis	☐	☐	Cancer (Non-skin)	☐	☐
Diabetes (sugar)	☐	☐	Latex/Rubber/Nickel/Food	☐	☐	Skin Disease	☐	☐
Kidney Disease	☐	☐	High Blood Pressure	☐	☐	Skin Cancer (Basal cell or Squamous cell)	☐	☐
Liver Disease or Hepatitis	☐	☐	Lung Disease	☐	☐	Melanoma	☐	☐
Infections Disease (TB, HIV, PPD)	☐	☐	Thyroid Disease	☐	☐	Keloids	☐	☐

Explain any positives above: _____

Any other conditions not included: _____

Past Surgeries: _____

Family History: (Check the following medical conditions which have occurred in your family)

Melanoma ☐ Psoriasis ☐ Eczema/Hayfever/Asthma ☐ Severe acne ☐

Social History: Do you drink alcohol? ☐ No ☐ Yes _____ drinks per week.
Tobacco Usage? ☐ No ☐ Yes _____ packs per day.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Updated: ___/___/___

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It is the policy of our office that **payment is due at the time of your appointment**. We will collect your co-pay amount or your deductible if you participate in a health plan for which we have a written contract. For your convenience, we do accept Visa and Mastercard.

PATIENT INFORMATION AND CONSENT

PATIENT NAME _____ SEX: MALE_____ FEMALE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

BIRTHDATE _____ EMPLOYER _____ OCCUPATION _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED ____ PARTNER ____

FAMILY PHYSICIAN OR PEDIATRICIAN _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

PRIMARY INSURANCE COMPANY NAME _____

If patient is a minor or the person financially responsible is someone other than the patient:

RESPONSIBLE PARTY _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTH DATE _____ SEX: MALE ____ FEMALE ____ EMPLOYER _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

Patient Responsibility

I understand that I will be held financially responsible for any balances incurred in this office or charges that are not paid by my insurance company due to annual deductibles, co-pay amounts, missed appointment charges, NSF checks, or accounts closed. If any balance is not paid when due, I agree to pay all costs of collection, including reasonable attorney fees, court costs, and the collection agency's fees. If my insurance plan requires a pre-authorization from my primary care physician, I am responsible for obtaining the pre-certification number prior to my appointment. If this has not been done, I will be asked to pay for my visit or asked to reschedule the appointment until this required information is obtained. We do accept assignment with Medicare; however, you will be responsible for annual deductible and co-pay amounts. A $30 fee will be assessed for missed appointments without 24-hour notice or for any returned checks.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND PAYMENT

I authorize the release of medical information deemed necessary to assist in my treatment and/or to my insurance company, should they request it, to facilitate processing of my medical charges. I authorized payment to be paid directly to the practice, Mina Swofford, M.D., P.C.

Signature: _____ Date: _____

You may contact me regarding medical care at home, at work, or by cell. And you may leave messages with another adult at home if I am unavailable.

Signature: _____ Date: _____

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REFERRAL INFORMATION

Patient name: _____

I selected this office because:

_____ Dr. Swofford has seen other family member(s). _____
relationship and name

_____ My friend recommended Dr. Swofford. _____
name

_____ My doctor recommended that I see the dermatologist of my choice.

_____ My doctor recommended Dr. Swofford.

_____
Doctor's name

_____
Address *(fill in only if he/she is outside of Madison County*

_____
City State Zip

_____ Internet

_____ Phone book advertisement

_____ Location

_____ Insurance list

_____ Other (please specify) _____

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I have been offered a copy of the Notice of Privacy Policies of this practice.

_____ _____
Signature Date

Please list family members or friends who may be assisting in your care or who may receive messages on your behalf. You do not need to list your doctors' names.

The practice has my permission to disclose PHI (protected health information) on my behalf to the following individuals:

_____

_____

_____

_____

_____

This will remain in effect until revoked in writing

_____
Printed Name

_____ _____
Signature Date