HAMPTON DERMATOLOGY, PC

325 Meeting House Lane
Southampton, NY 11968

(631)283-3131

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Sex _____

Social Security No. _____ Marital Status _____

BILLING ADDRESS:

Street / PO Box _____

City _____

State _____ Zip Code _____

****(please star primary phone number below)****

Home Phone _____

Cell Phone _____

Work Phone _____

LOCAL ADDRESS: (If applicable)

Street / PO Box _____

City _____

State _____ Zip Code _____

Local Phone _____

Employer/ School _____

Email address _____

Emergency Contact _____

INSURANCE INFORMATION: Please Present ALL insurance cards at the front desk at the time of your visit.

Primary Insurance _____ **Secondary Insurance** _____

IF POLICY HOLDER IS *NOT* THE PATIENT OR IF PATIENT IS A MINOR PLEASE FILL OUT THIS SECTION:

POLICY HOLDER / RESPONSIBLE PARTY INFORMATION

Policy Holder / Parent _____ Date of Birth _____ SSN _____

Relationship to patient _____ Address _____

Home Phone _____ City _____

Work Phone _____ State _____ Zip Code _____

PRIMARY PHYSICIAN: Please Note: If your insurance company requires a referral for specialists. A referral must be filled out by your Primary Doctor.

Name: _____ Phone _____

Address _____

MY PHARMACY: _____ Phone _____

Hampton Dermatology, PC does not participate with all insurance plans. If Hampton Dermatology, PC does not accept my insurance or I have no insurance coverage, I understand that I am expected to pay in full on the day that professional services are rendered, unless other arrangements have been made in advance. If Hampton Dermatology, PC does accept my insurance, I understand that I am responsible for any amount not covered by my insurance, including deductibles and co-payments.

I hereby authorize treatment of my/my dependants medical condition by Hampton Dermatology, PC.

I hereby authorize Hampton Dermatology, PC to furnish information to my insurance plan(s) concerning my illness and treatment, and assign to the physician all payments for medical services rendered to myself and my dependants. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature _____ Date _____

PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____

Are you allergic to any medications? Yes or No (please list)
_____SEE ATTACHED SHEET_____

Are you currently taking any medications, including over the counter medications? Yes or No (please list)
_____SEE ATTACHED SHEET _____

Have you ever been treated for any of the following? (please circle)

Heart disease or pacemaker	yes	no
High blood pressure	yes	no
Emotional / Physical Problems	yes	no
Venereal Disease	yes	no

Have you or anyone in your family had any of the following: (please circle and list family member if other than yourself)

Asthma	yes	no	_____
Hay Fever	yes	no	_____
Hives	yes	no	_____
Eczema	yes	no	_____
Diabetes	yes	no	_____
Psoriasis	yes	no	_____
Skin Cancer	yes	no	_____
Melanoma	yes	no	_____

In the last 6 months have you had an accident or operation?

_____

_____

Have you ever been treated for a skin disorder before?

_____

_____

Have you ever had a treatment for the skin called grenz ray treatments? Yes No Not Sure

I use sunscreen: always sometimes never

I smoke: always sometimes never

Do you drink? (how much?) _____

_____

What soap do you use? _____

_____

What moisturizer do you use? _____

_____

Are you pregnant or planning a pregnancy?
Yes No

Do you take birth control pills?
Yes No

HIPPA:

In order to ensure your privacy Hampton Dermatology, PC will only discuss your medical records with you, unless written consent is granted to do otherwise.
If you wish to permit other person (s) (i.e. husband, wife, parent, doctor, etc) to discuss your medical condition with us or to have access to your medical records, those person (s) must be listed below.

NOTE: This consent will remain in effect until changed in writing by the patient or guardian.

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

To the best of my knowledge, the medical information provided is correct.

Signature _____

Date: _____

HAMPTON DERMATOLOGY
325 MEETING HOUSE LANE, STE. J
SOUTHAMPTON, NY 11968-5087

PATIENT MEDICATION LIST

Name: _____ DOB: _____

ALLERGIES: _____ ALLERGIC REACTION: _____

Medication Name (write clearly)	Dose	Route	How often taken	

_____

_____

_____

Signature Date

☐ Dosages and/or Frequency not available

_____