PATIENT INFORMATION

Last Name:	Primary Physician:
First Name: M.I.	Referring Physician:
Previous Name:	Birth Date: Age: ❍ Male ❍ Female
Email: ❍Web enable?	Social Security #:
Address:	❍ Single ❍ Divorced ❍ Married ❍ Widowed
	Emergency Contact:
City/State/ZIP	Relationship: Ph: ( )
Home Ph: ( ) Cell: ( )	**Ethnicity**: ❍ Hispanic ❍ Not Hispanic ❍ Prefer not to answer
Employer: ______________________________ Work Ph: ( ) Ext:	**Race:** ❍ American Indian/Alaska Native ❍ Native Hawaiian ❍ Asian ❍ Black or African American ❍ White ❍ Other

INSURANCE SUBSCRIBER INFORMATION

Please choose one: O Self O Other established Patient O Non-Patient

Name:	Relationship:
Address:	Social Security #: Birth Date:

INSURANCE/PHARMACY INFORMATION

Primary Insurance: ______________________________ Secondary Insurance: ______________________

****PLEASE provide INSURANCE CARD & DRIVERS LICENSE to the receptionist to copy for your file.**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Haynes. I understand that I am financially responsible for any balance. Permission is hereby granted to Dr. Melanie Haynes to render such medical and/or surgical treatment only after it has been discussed and deemed necessary and to release any information including exam, diagnosis and treatment to my insurance carrier which may be required in order to process my claims.

Patient/Guardian Signature: Date:

Preferred Pharmacy Name: Phone/Closest Intersection:

IF YOU'RE A MEDICARE PATIENT, PLEASE SIGN THE TWO AUTHORIZATIONS BELOW:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Dr. Melanie Haynes. Regulations pertaining to Medicare assignment of benefits apply.

X____ Date: ________________

Signature as it appears on Medicare Card

I authorize Medigap (secondary insurance) benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap (secondary) carrier any information needed to determine these benefits payable for related services.

X____ Date: ________________

Signature as it appears on Medigap (secondary) Carrier Card

PATIENT NOTICE OF PRIVACY PRACTICES

The entire Private Policy Notices of Dr. Melanie Haynes are posted in the waiting room for your review. By signing this form, you acknowledge that you have read this laminated HIPAA notice provided. In conjunction with these privacy practices you will need to provide us with the following information:

1. **Name** of person(s) we may speak to regarding your health (i.e. spouse, child, etc. **including phone number**)

____

2. YES: ❍ NO:❍ **May we** leave a message regarding your health or an upcoming appointment on your answering machine?

______________________ ______________________ ______________________

Signature of Patient or Legal Guardian Print Patient's Name or Legal Guardian Relationship to Patient

______________________ __________

Signature of Witness Date

SWC MEDICAL QUESTIONAIRE

Have you ever experienced any of the following? ***Please fill in the circles****: yes or no* ●

Unexplained weight change	O Yes	O No
Unexplained fever	O Yes	O No
Poor wound healing	O Yes	O No
Excessive scarring	O Yes	O No
Easy bruising	O Yes	O No
Recurrent or persistent rashes	O Yes	O No
Suspicious skin lesions	O Yes	O No
Itchy eyes	O Yes	O No
Symptoms of Hay Fever	O Yes	O No
Wheezing	O Yes	O No
Angina	O Yes	O No
Arthritic complaints	O Yes	O No
Difficulty swallowing	O Yes	O No
GI absorption disorder	O Yes	O No
Anxiety	O Yes	O No

⇨PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name: ______________________________

Date: ______________________________

Medication Allergies: ______________________________

____

____

Current Medications: ______________________________

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____

____

____

____

Signature **Date** **Witness**

Family History of?

Eczema	O Yes	O No
Autoimmune disease	O Yes	O No
Psoriasis	O Yes	O No
Melanoma	O Yes	O No

Tell us about your Social History

Spend most time	O Indoors	O Outdoors
Alcohol	O Yes	O No
Smoking	O Yes	O No
Sunscreen use	O Daily	O Infrequently

Past Medical History of?

Skin Cancer	O Yes	O No
Melanoma	O Yes	O No
Psoriasis	O Yes	O No
Reaction to anesthetics	O Yes	O No
Fever Blisters	O Yes	O No
Latex Allergy	O Yes	O No

Mark any below that apply?

O Pacemaker	O Irregular heartbeat	O Asthma
O HIV	O Clotting Abnormality	O Hepatitis C
O Emphysema	O Seizures	O Environmental allergies
O Heart Attack	O Hypertension	O Heart murmur
O Bleeding Abnormality	O Rosacea	
O Diabetes	O Fainting spells	