



DR. MONICA MCCRARY

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NEW / UPDATED PATIENT INFORMATION

Last Name: _____
First Name: _____
Preferred Name: _____
Middle Name: _____ Suffix: _____
Former Last Name: _____
Gender: _____
Date of Birth: ____ / ____ / ____
Address: _____
Address: (Apt., Unit, etc.): _____
Zip Code: _____
City: _____ State: _____

I wish to be contacted in the following manner:

Home Phone: (____) _____
 Mobile Phone: (____) _____
 Work Phone: (____) _____
Extension: _____

Primary Insurance

Insurance Company: _____
Patient's relationship to Policy Holder:
 Self Spouse Child Other _____
Policy Holder Last Name: _____
Policy Holder First Name: _____
Policy Holder Date of Birth: ____ / ____ / ____
Policy Holder Gender: _____

Secondary Insurance

Insurance Company: _____
Patient's relationship to Policy Holder:
 Self Spouse Child Other _____
Policy Holder Last Name: _____
Policy Holder First Name: _____
Policy Holder Date of Birth: ____ / ____ / ____
Policy Holder Gender: _____

Have you specifically authorized anyone to make healthcare decisions for you should you become Incompetent and unable to make those decisions yourself? ____ Yes ____ No

If yes: Name: _____ Telephone Number: _____ Relationship to the Patient: _____

If yes: Name: _____ Telephone Number: _____ Relationship to the Patient: _____

Have you created a **written** Power of Attorney for purposes or your healthcare? ____ Yes ____ No

If yes, please provide a copy of that document(s) to our practice at your earliest convenience.

Confidential and Proprietary



DR. MONICA MCCRARY

NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

1. Cibolo Creek Dermatology Group has made the Notice of Privacy Practices available to me.
2. Cibolo Creek Dermatology Group may access, collect, use and disclose my health information to my primary care or referring physician, to consultants, and as necessary to others to process insurance claims, insurance applications and prescriptions.
3. Cibolo Creek Dermatology Group may also disclose my health information these persons:

Name: _____ Phone:(_____) _____ Relationship to the Patient: _____

Name: _____ Phone:(_____) _____ Relationship to the Patient: _____

4. This authorization is effective for all of my records, including past records, and remains in effect until it is revoked in writing, unless date is specified here:
5. Cibolo Creek Dermatology Group may provide me with information on activities and developments, and may disclose my information to third parties who help Cibolo Creek Dermatology Group to inform me. This authorization expires 3 years after my last appointment.
6. I may revoke this authorization, in writing, at any time. This would not be effective to the extent that anyone has already relied on it, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. My treatment, payment, enrollment, or eligibility for benefits is not to be conditioned on this authorization.

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Patient's Preferred Phone#: Patient's Email Address:	When contacting me (please check one): <input type="checkbox"/> Leave a message with detailed information. <input type="checkbox"/> Leave a message with a call back number only. <input type="checkbox"/> Do NOT leave a message.
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Name of Patient's Primary Care Provider (Primary Medical Doctor):

If possible, please provide this person's Phone # and Fax #:

Pharmacy Name: _____ Phone: (_____) _____

Street: _____

City: _____ State: _____ Zip Code: _____

TODAY'S CHIEF CONCERNS:

Please list the specific skin concerns or questions you would like addressed today:

- 1)
- 2)
- 3)

PAST MEDICAL HISTORY:

Which of the following medical conditions or treatments have you ever had? *Check all that apply.*

HIV/AIDS	Hepatitis B	Hepatitis C	Diabetes	Tuberculosis
Biologic Therapy/ Chemotherapy	Organ or Bone Marrow Transplantation	Radiation Treatment	Cancer (If YES, which types:)	

Please list any other known medical conditions, surgeries, and hospitalizations:

Patient/Legal Guardian's Signature:	<i>(Office use only)</i> Entered into EMA by:
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SKIN CONDITION HISTORY: Have you ever been diagnosed with or treated for Melanoma? YES NO If YES, please provide more detail:			
Have you ever had any of the following skin conditions?			
Basal Cell Carcinoma	Squamous Cell Carcinoma	Sebaceous Cell Carcinoma	Merkel Cell
Angiosarcoma	Blistering Sunburns	Eczema	Carcinoma Psoriasis

FAMILY HISTORY OF MELANOMA: Have any of your "first degree relatives" (parent, brother, sister, or child) ever been diagnosed with Melanoma? YES NO If YES, which relatives:	
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MEDICATIONS: Please list any current prescription and "over-the-counter" medications AND any alternative or complementary therapies AND supplements that you use or take. Please include the name of the product, how much, and how often you use or take it. Use the back of this sheet to continue if necessary.		
MEDICATION #1	How much (dose)?	How often (frequency)?
MEDICATION #2	How much (dose)?	How often (frequency)?
MEDICATION #3	How much (dose)?	How often (frequency)?
MEDICATION #4	How much (dose)?	How often (frequency)?
MEDICATION #5	How much (dose)?	How often (frequency)?
MEDICATION #6	How much (dose)?	How often (frequency)?
MEDICATION #7	How much (dose)?	How often (frequency)?
MEDICATION #8	How much (dose)?	How often (frequency)?
MEDICATION #9	How much (dose)?	How often (frequency)?
MEDICATION #10	How much (dose)?	How often (frequency)?

Patient/Legal Guardian's Signature:	(Office use only) Entered into EMA by:
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ALLERGIES:

Do you have any known allergies (including medications, foods, latex, bandage tape)? YES NO

If YES, please provide more detail:

SOCIAL HISTORY:

What is your current Smoking Status? Never Smoker Former Smoker Current Smoker

QUALITY MEASURES:

1) Have you ever received a Pneumonia vaccination? YES NO

2) Do you have a health care proxy In the event you are unable to make your own medical decisions)? YES NO

If YES, provide the Designee's name:

If YES, provide the Designee's phone number:

3) Do you have a Living Will (Advanced Care Plan)? YES NO

If you are a FEMALE patient (otherwise leave blank)...

Are you pregnant or trying to become pregnant? YES NO

Are you nursing or breastfeeding? YES NO

Patient/Legal Guardian's Signature:

(Office use only) Entered into EMA by:

ALERTS:

- 1) Have you had a flu vaccination (shot or intranasal spray) in the past year? YES NO
- 2) Have you traveled outside of the continental United States in the past 3 months? YES NO
- 3) Do you currently have a pacemaker? YES NO
- 4) Do you currently have a defibrillator? YES NO
- 5) Do you have any artificial heart valves, joints, plates, screws, rods, stents, pins, etc.?
If YES, were any placed within the last 2 years? YES NO
- 6) Do you require any medications prior to a surgical procedure? YES NO
If YES, for which procedures?
If YES, what medications do you require?
- 7) Are you taking any medications that cause you to bleed more easily (“blood thinners”)? YES NO
- 8) Have you ever experienced a rapid heartbeat with epinephrine? YES NO
- 9) Have you ever been treated with “gold” (gold sodium thiomalate) therapy? YES NO

FAMILY HISTORY

Do any of your “first degree relatives” (parent, brother, sister, or child) have any of the following conditions? *Check all that apply.*

- | | | | | |
|-----------------------------|---------------------------------|-------------------------------|-------------|-------------------|
| Eczema | Asthma | Hay Fever/ Seasonal Allergies | Psoriasis | Arthritis |
| Thyroid Problems | Lupus/Connective Tissue Disease | Diabetes | Stroke | Blood Clots |
| Crohn’s/ Ulcerative Colitis | Vitiligo | Scarring/ Keloids | Severe Acne | Pancreatic Cancer |

Skin Cancer: If YES, please provide more detail:

Patient/Legal Guardian’s Signature:

(Office use only) Entered into EMA by: