Housel Dermatology, P.C.

Joseph P. Housel, MD
Mohs and Reconstructive Surgery
235 Greenfield Parkway
Liverpool, NY 13088
Phone (315) 452-3376
Fax (315) 452-3377

Patient Information Date _____

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Referred By: _____ Phone: _____
Address: _____ City: _____
Zip: _____ Email: _____
Home Phone: _____ Cell: _____ May we leave a message? ☐ Y ☐ N
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Employer: _____ Work Number: _____

Ethnic Group
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Race
- ☐ White
- ☐ African American
- ☐ American Indian or Alaska Native
- ☐ Hispanic
- ☐ Other race

Emergency Contact: _____ Relationship: _____
Emergency Phone: _____

Insurance Information
Insurance Company: _____ Policy Holder: _____
Policy Number: _____ Relationship to patient: _____
Group Number: _____ Policy Holder DOB: _____
Effective Date: _____ Policy Holder SS#: _____

Secondary Insurance
Insurance Company: _____ Policy Holder: _____
Policy Number: _____ Relationship to patient: _____
Group Number: _____ Policy Holder DOB: _____
Effective Date: _____ Policy Holder SS#: _____

I certify that the information given by me in applying for payment under my insurance carrier is correct. I authorize any holder if medical/insurance information about me to release to my physician/insurance any information required to process my claims. I understand that to knowingly withhold insurance reimbursement payments for medical services rendered services to rendered would be committing a wrongful act. I request that reimbursement from my insurance be made payable to the physician's office that rendered services to me. I attest that the information I have given on these forms is true and correct to the best of my knowledge.

Signature: _____ Date: _____

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Acknowledgment of
Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA),
I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- **Treatment:** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- **Payment:** Obtain payment from third-party payers.
- **Operations:** Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that should I request a copy of Housel Dermatology, P.C.'s privacy practices containing a more complete description of the uses and disclosures of health information, one will be provided. I understand that this organization has the right to chance its Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I authorize Dr. Housel and/or his staff to discuss my medical condition, including laboratory findings with the following individuals:

_____

_____

_____

_____

Signature: _____ Date: _____

Patient Printed Name: _____ Relationship to Patient: _____

Medical practice use only

If patient refuses to sign, a good faith effort was made to obtain the patient's or authorized representative's written acknowledgement of Privacy Practices. The reason the patient or authorized representative acknowledgment was not obtained is as follows:

_____

_____

_____

_____

Documented by: _____ Date: _____

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Patient Name: _____ **Primary Care Physician:** _____
Date: _____ **Referring Physician:** _____
Date of Birth: _____ **Email:** _____

1. Select any of the following medical conditions that you are *currently* having:

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stoke
- ☐ Other

2. Please list any surgeries or hospitalizations and the dates:

Date	Procedure

3. Have you had any of the following skin conditions?

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Blistering Sunburns
- ☐ Eczema (Dry Skin)
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Squamous Cell Carcinoma
- ☐ Other

Do you wear sunscreen? ☐ Y ☐ N
If yes, what SPF? _____
Do you tan in a tanning salon? _____
Do you have a family history of melanoma? ☐ Y ☐ N
If yes, which relatives? _____

4. Do you drink alcohol?

- ☐ None
- ☐ Less than 1 Drink per week
- ☐ One Drink Per Week
- ☐ 2-3 drinks per week
- ☐ 3 or More drinks per week

Do you Smoke?

- ☐ Never smoked
- ☐ Former Smoker
- ☐ Current Smoker
- ☐ Smokeless tobacco
- ☐ Cigar

5. Please list any medications you are currently taking, including over-the-counter:

Medication	*Dosage*	*Frequency*

6. Do you have any allergies to medications, latex, adhesives, or other sensitivities?

_____

7. Are you experiencing difficulty *today* with any of the following?

- ☐ None
- ☐ Problems with bleeding
- ☐ Immunosuppression
- ☐ Fever or Chills
- ☐ Shortness of breath
- ☐ Chest Pain
- ☐ Unintentional weight loss
- ☐ Night Sweet
- ☐ Blurry Vision
- ☐ Abdominal pain
- ☐ Muscle weakness
- ☐ Headaches
- ☐ Anxiety
- ☐ Depression
- ☐ Bloody stool
- ☐ Thyroid problems
- ☐ Other _____

8. Family health history (1st degree relative): (Ex Heart disease, Cancer, Asthma, Diabetes, Allergies)

_____

_____

9. Please describe the reason for your visit to the dermatologist today, include how long the problem has been present and all treatments.

_____

_____

10. What is your occupation? _____

Emergency Contact: _____

Relationship to patient: _____

Phone number: _____

11. Which pharmacy do you use? (PLEASE BE SPECIFIC)

Name _____ Phone Number _____

Address _____ City/State _____