KATHY FANG, MD, PHD. INC., DERMATOLOGY

INFORMATION FOR MEDICAL RECORDS DATE ________________________

PATIENT NAME ____
Last First MI

____ MALE ____ FEMALE _____ MARRIED _____ UNMARRIED _____ PARTNERED

ADDRESS ____________________________________,___________________,________,____________________
City State Zip+ 4

DATE OF BIRTH _____/________/_______ AGE _________ HOME PHONE ____________________________

EMAIL ADDRESS ________________________________ SOCIAL SECURITY NUMBER ____________________

WORK #______________ CELL #______________PHARMACY NAME & LOCATION_________________________

EMERGENCY CONTACT ______________________ RELATIONSHIP ______________________________

HOME PHONE ________________ WORK # ____________________ CELL # ___________________________

SMOKER_____ never ____current____ former ETHNICITY__________________________________

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE BELOW

NAME ____ DATE OF BIRTH______________________
Last First MI

ADDRESS __________________________________,____________________,________,___________________
City State Zip + 4

HOME PHONE _________________ WORK PHONE _______________ CELL PHONE ___________________

RELATIONSHIP TO INSURED_____________________SOCIAL SECURITY NUMBER___________________

INSURANCE INFORMATION: please give insurance card to the receptionist to copy.

PRIMARY CARE PHYSICIAN ________________________________ PHONE ___________________________

PRIMARY INSURANCE ____

SECONDARY INSURANCE ____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

As patient or as legal guardian of patient, I agree to pay for all service rendered. This office may bill my insurance carrier as needed. Hereby

— I authorize this office and its billing company to release of any medical information necessary to process this request.
— I authorize payment of medical benefits directly to Kathy Fang, M.D., Ph.D. Inc.
— I am financially responsible for non-covered services.

I state that the above information is correct to my knowledge. I have read and agree to comply with the office policy stated in patient information sheet.

SIGNED (INSURED OR AUTHORIZED PERSON) ____

(please continue on reverse side)

DERMATOLOGY MEDICAL HISTORY **DATE** ____________________

PATIENT NAME ____
Last First MI

REASON FOR APPOINTMENT ____

ARE YOU ALLERGIC TO ANY MEDICATIONS / LATEX? YES_____ NO _____ If yes, list the medication and the bad reaction

____

DO YOU TAKE FOLLOWING MEDICATIONS: aspirin ___, ibuprofen ___, coumadin ___, vitamin E___, ginkgo___, ginseng ___

Please specify the reason for taking these meds ____

DO YOU TAKE ANTIBIOTICS BEFORE DENTAL CLEANING OR OTHER PROCEDURES? Yes _______ NO _________

If yes, state why and the name of antibiotics ____

LIST ALL OTHER MEDICATIONS YOU ARE TAKING (including prescriptions, over-the-counter and herbal meds)

____

DO YOU OR YOUR IMMEDIATE FAMILY MEMBERS (BLOOD RELATIONS) HAVE OR EVER HAD THE FOLLOWING ILLNESSES OR CONDITIONS:
If yes, please specify

SKIN CANCER (including melanoma) YES ___ NO___ specify _________________________________

ECZEMA, ASTHMA, SEASONAL ALLERGY YES ___ NO___ specify ___________________________

SCAR/SKIN HEALING PROBLEM YES ___ NO___ specify _________________________________

HEART PROBLEM (including high blood pressure) YES ___ NO___ specify ___________________

BREATHING/LUNG PROBLEM YES ___ NO___ specify _____________________________________

JOINT PROBLEM (including joint replacement) YES ___ NO___ specify ______________________

HORMONAL IMBALANCE (including diabetes, thyroid, other hormones) YES ___ NO ___ specify ____________

INFECTIONS YES ___ NO___ specify ____

CLOTTING/BLEEDING PROBLEM YES ___ NO___ specify ________________________________

STOMACH/BOWEL PROBLEM YES ___ NO___ specify ____________________________________

URINATION/BLADDER/KIDNEY PROBLEM YES ___ NO___ specify __________________________

EMOTION/PSYCHIATRIC PROBLEM (including depression) YES ___ NO___ specify _________________

FAINTING/SEIZURE YES ___ NO___ specify ____

HISTORY OF SURGERY YES ___ NO___ specify ______________________________________

LIST ALL OTHER CONDITIONS NOT INCLUDED IN ABOVE LIST ___________________________