(UPDATE) PATIENT INFORMATION SHEET (PLEASE PRINT) **Chart #:_____**

LAST VISIT DATE: _____

Patient Name:	DOB:	AGE:	SS#:
Guardian, (**if patient is a minor**):	Relationship:	**REFERRING DOCTOR:**	
Physical Street Address:	**Martial Status:** M:___S:___D:____W:____	**Sex:** M:___ F:____	
City/State/ZIP:		Race: _____	
(H) PHONE #:	(C) PHONE #:		
Employer: _____ FT:____ PT:____ DISABLED:____ RETIRED: ____	**(W) PHONE #:** _____	**STUDENT:** FT: _____ PT: _____	

Mailing Street Address, (**if different from above**):
City/State/Zip:

Primary Insurance:

ID#:	Group#:	Employer:
Policy Holder Name:	DOB:	Relationship:

Secondary Insurance:

ID#	Group#	Employer:
Policy Holder Name:	DOB:	Relationship:

Emergency Contact:	**Phone#:**	**Relationship:**

Medical Skin History

1. Describe the skin problem that brought you to this office._____
2. How long have you had this problem? _____
3. What have you used to treat the current problem? _____
4. Have you ever experienced a blistering sunburn or been treated with chemotherapy or radiation? Yes__No__ Please explain: _____
5. Have you used prednisone, cortisone, or any other steroid over an extended period of time? Yes____No____ Please explain: _____
6. Please list any other prior skin problems. _____

Please read and check the following statements in acknowledgement that you have read/been offered and understand the Financial Policy and Privacy Notice. These documents are available at request and in the manuals provided in the Office Lobby.

☐ I have read/been offered, understand and consent to Dr. John M. Humeniuk HIPAA Patient Privacy Policy.

☐ I have read/been offered, understand and REFUSE to consent to the HIPAA Patient Privacy Policy.

☐ **I understand that, if my INSURANCE requires a COPAY/COINSURANCE or you are SELF PAY, payment is due at the time of service, and there will be a $20 billing fee in the event that I do not pay at my appointment time.**

☐ I understand that, we file Insurance Claims to **CONTRACTED** insurance companies only. In the event your insurance company denies your claim for any reason the charges will be released to you or guardian that's responsible for payment.

Signature of Patient or Legal Guardian: _____ Date: _____