Dermatology Medical Group of Oxnard

Patient Name: _____ Date: _____
Last First Middle

Birthdate: _____ Sex: _____ Phone(s): _____

Home Address: _____
Number Street City Zip Code

Referred By: _____ Marital Status: _____

Patient Occupation: _____ Employed By: _____

Work Address: _____ Phone: _____

Spouse: _____ Spouse Phone: _____

Emergency Contact: _____
Contact Name Address Phone

• Insurance Information

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

Assignment & Release: I hereby assign my insurance benefits to be paid directly to **Dermatology Medical Group of Oxnard**. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

Signature: _____ Date: _____

If someone other than patient is subscriber, complete below:

Name: _____
Last First Middle

Home Address: _____ DOB: _____ Phone: _____

• Chief Complaint: _____

_____

• Medical Information (Mark with 'X' if pertinent and explain if needed):

Personal History:
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Heart pacemaker
- ☐ Diabetes
- ☐ Stomach ulcers/reflux disease
- ☐ Skin cancer
- ☐ Internal cancer
- ☐ Bleeding problems
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Asthma/hay fever
- ☐ Hepatitis A B C
- ☐ Tuberculosis
- ☐ HIV
- ☐ Seizures
- ☐ Psoriasis
- ☐ Eczema

Current Problems With:
- ☐ Weight loss
- ☐ Fever/chills
- ☐ Dizziness
- ☐ Eyes
- ☐ Ears, nose, throat, or mouth
- ☐ Heart
- ☐ Lungs
- ☐ Stomach/bowel
- ☐ Kidneys
- ☐ Arthritis
- ☐ Depression/anxiety
- ☐ Seizures

Females only:
- ☐ Currently pregnant
- ☐ Planning to become pregnant
- ☐ Currently breastfeeding

Social History:
- ☐ Current smoker
- ☐ Past smoker
- ☐ Alcohol consumer
- ☐ IV drug use
- ☐ Pets at home

Family History:
- ☐ Heart disease
- ☐ Diabetes
- ☐ Internal cancer
- ☐ Skin cancer
- ☐ Bleeding problems
- ☐ Asthma/hay fever
- ☐ Psoriasis
- ☐ Eczema

List medications/herbs: _____

_____

_____

_____

List major surgeries: _____

_____

_____

_____

List drug allergies: _____

_____

_____

_____