Jeff Alexander, M.D.
DERMATOLOGY
A Professional Corporation

6565 S. Yale Ave, Suite 503 • Tulsa, OK 74136 • 918-494-8333

PATIENT INFORMATION RECORD

PLEASE PRINT

Have you been a patient at our clinic before? NO ❑ YES ❑ When? _____

Birth Date_____ **Age**____ **Sex**____

PATIENT'S

Full Name _____ Nickname _____
LAST FIRST MIDDLE

Mailing Address _____ Apt # _____ City _____ State_____ Zip_____

Email Address _____

Phone (H) _____ (C)_____ SS# _____ Marital Status _____

Employer_____ Employer's Phone _____

Spouse's Name_____ Cell Phone (___)_____

In case of emergency, notify _____ Phone _____ Relationship_____

Primary Care Physician _____ Phone _____

AUTHORIZATION FOR MEDICAL TREATMENT & MEDICATION HISTORY

Office Practice/Clinic personnel at this facility are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

RELEASE OF PROTECTED HEALTH INFORMATION

Information may be released to the following individual(s)

Name (Please Print)	Relationship	Name (Please Print)	Relationship
Name (Please Print)	Relationship	Name (Please Print)	Relationship

May we have your permission to leave medical information on your voicemail or machine? ❑ Yes ❑ No Phone #_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. **I understand I'm financially responsible for charges not covered by my insurance.** I further authorize:

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier information needed to determine benefits.

I further agree that all information submitted is true, correct and complete as of the date of my signature.

X _____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR Date

Please present your insurance card(s) and a photo ID to the receptionist along with completed form(s). Thank you.

Patient's Name: _____ Date of Birth _____

Reason for visit: _____

Please check if you or your family had/has any of the following: **If no symptoms, check None ❑**

Please Indicate: (M) Mother (F) Father (B) Brother (S) Sister

MED HX

PROBLEM	SELF	Family Member
Anxiety		
Asthma		
Arthritis		
Atrial Fibrillation		
Cancer Type _____		
COPD		
Coronary Artery Disease		
Depression		
Diabetes		
GERD		
Hearing Loss		
Hepatitis		
HIV/AIDS		
High Blood Pressure		
High Cholesterol		
Hypothyroidism		
Lymphoma		
Seizures		
Strokes		

ROS

PROBLEM	SELF	Family Member
Pregnant or Nursing		
Artificial Heart Valve		
Defibrillator		
Dry Crusty Nose		
Dry Eyes or Blurry Vision		
Easy Bleeding or Bruising		
Fever or Chills		
GI Upset & Antibiotics		
Immunosuppression		
Muscle Weakness		
New Tender Pimples		
Night Sweats		
Pacemaker		
Painful Joints		
Pimples on Back of Neck		
Problems Healing		
Scarring Problems		
Weight Gain or Loss		
Tanning Bed Use		

SKIN HX

PROBLEM	SELF	Family Member
Acne		
Actinic Keratosis		
Basal Cell Carcinoma		
Squamous Cell Carcinoma		
Melanoma		
Blistering Sunburns		
Dry Skin		
Eczema		
Flaking or Itchy Scalp		
Hay Fever / Allergies		
Poison Ivy		
Precancerous Moles		
Psoriasis		
Herpes Simplex (Cold sores)		
Herpes Zoster (Shingles)		
Other _____		
Other _____		
Other _____		
Other _____		

Family or personal history of melanoma skin cancer (in a 1st degree relative) ❑Yes ❑No If yes, who _____

Please list all previous **surgeries** and dates:

Surgery	Date	Surgery	Date	Surgery	Date
1. _____	_____	3. _____	_____	5. _____	_____
2. _____	_____	4. _____	_____	6. _____	_____

Please list all **medications** (include birth control, over the counter and herbal medications you routinely take: **or provide list:**

Medication / Amount	Dosage	Medication / Amount	Dosage	Medication / Amount	Dosage
1. _____	_____	3. _____	_____	5. _____	_____
2. _____	_____	4. _____	_____	6. _____	_____

Preferred Pharmacy _____ **Phone** _____

Allergic to Latex, Lidocaine or Epinephrine? ❑ Yes ❑ No If yes, list here: _____

Are you **allergic** to any medications? ❑ Yes ❑ No If yes, list here with reaction: _____

_____

Have you had a **flu vaccine**? ❑Yes ❑No When? _____ Have you had a **pneumonia vaccine**? ❑Yes ❑No When? _____

Do you smoke? ❑Yes ❑No Former Smoker? ❑Yes ❑No

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

Date _____

I have received a copy of Jeff Alexander, MD, PC Notice of Privacy Practices.

X _____ _____

Signature Please Print Name

OFFICE USE ONLY We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

❑ Individual Refused to Sign
❑ Communications barriers prohibited the acknowledgment
❑ An emergency situation prevented us from obtaining acknowledgment
❑ Other: _____