Gem State Dermatology, P.A.
388 E. Parkcenter Blvd Boise, ID 83706
Phone: (208) 424-9101 FAX: (208) 424-5072
www.gemstatedermatology.com

Patient Information Form

This form contains medical information. Please print (do not email it to us).

PATIENT INFORMATION

Patient Name: Last, First, M.I.	Date of Birth	Social Security #
Mailing Address	Apt, Ste., or Unit#	☐ Female ☐ Male
City / State / Zip Code	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Partner	
Home Phone# / Cell Phone# / Work Phone#	Email Address	

Race:
☐ American Indian or Alaskan Native ☐ Hispanic
☐ Asian ☐ White
☐ Black or African American ☐ Other
☐ Native Hawaiian or Other Pacific Islander

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Other_____

Preferred Language:
☐ English
☐ Spanish
☐ Other_____

May we leave personal medical information on your voice mail?
☐ Yes ☐ No / ☐ Home ☐ Cell

How would you like to receive appointment reminders?
☐ Phone call ☐ Text ☐ Email ☐ Any / all

PATIENT RESPONSIBLE FOR CHARGES

Is the patient a minor? ☐ Yes ☐ No If yes, what is the patient's relationship to the responsible party?_____

If patient is a minor, please indicate if parents are: ☐ Married ☐ Separated ☐ Divorced

If person responsible for payment is different from patient, then complete section below.

Last, First, M.I.	Date of Birth	Social Security #
Mailing Address		Apt, Ste., or Unit#
City / State / Zip Code		☐ Female ☐ Male
Patient Relationship to the Responsible Party: ☐ Spouse ☐ Child ☐ Other (please list)	Preferred Phone Number for Contact	

EMERGENCY CONTACT INFORMATION

In Case of an Emergency Notify (Full Name)	Phone	Relationship to Patient

PERSONAL REPRESENTATIVE

May we discuss your medical condition(s) with another person? If yes, whom:

INSURANCE INFORMATION

Primary Insurance

Insurance Name:_____
Policy/ID#:_____
Group#:_____
Primary Policy Holders Name:_____
Date of Birth:_____SS#:_____
Address of Insured:_____
_____
Relationship to the patient: _____

Secondary Insurance

Insurance Name:_____
Policy/ID#:_____
Group#:_____
Primary Policy Holders Name: _____
Date of Birth:_____SS#:_____
Address of Insured:_____
_____
Relationship to the patient:_____

I hereby certify that the above information is true and correct to the best of my knowledge and that I am the above-named patient or the duly authorized general agent of the above-named patient, authorized to furnish the information requested, and seek and authorize health care services. I understand that it is my responsibility to find out what my insurance coverage options are with my insurance company. I further understand that Gem State Dermatology (GSD) will assist me in obtaining authorization if necessary, however, ultimately it is my responsibility as the patient to determine if a prior authorization is required. I authorize GSD to furnish medical records and any other information necessary to process and obtain payment from my insurance company. This information may be released to my primary care physician and, upon request, to any other healthcare provider who may need the information for continuity of care. This release of information will remain in effect until revoked by me in writing. I understand and agree that I am responsible for payment of all charges including those not paid by my insurance in a reasonable time. I hereby assign all applicable benefits and direct that payment be made directly to Gem State Dermatology, PA for all services provided to/for me during my visits. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines. Any patient that does not show for their scheduled office visit appointment and does not call within 24 hours to cancel or to reschedule, will receive a $25.00 charge. As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by GSD and I acknowledge the receipt of a copy of GSD's Notice of Privacy Policy.

Patient or Responsible Party Signature: _____ Date: _____

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Medical History Intake Form

PATIENT INFORMATION

Patient Name: Last, First, M.I.	DOB	Age
Primary Care Physician/Referring Physician	Preferred Pharmacy (name and location)	
May we release/discuss your medical information with other people? ❑ Yes ❑ No	If yes, whom?	

PAST MEDICAL HISTORY (please check all that apply)

❑ Anxiety	❑ Colon Cancer	❑ Hearing Loss	❑ Leukemia
❑ Arthritis	❑ COPD	❑ Hepatitis ❑ A ❑ B ❑ C	❑ Lung Cancer
❑ Asthma	❑ Coronary Artery Disease	❑ Hypertension	❑ Lymphoma
❑ A Fib (irregular heartbeat)	❑ Depression	❑ HIV/AIDS	❑ Prostate Cancer
❑ Bone Marrow Transplant	❑ Diabetes	❑ High Cholesterol	❑ Radiation Treatment
❑ BPH (enlarged prostate)	❑ End Stage Renal Disease	❑ Hyperthyroidism	❑ Seizures
❑ Breast Cancer	❑ Gastric Reflux	❑ Hypothyroidism	❑ Stroke
❑ Other (please list)			
❑ None			

PAST SURGICAL HISTORY (please check all that apply)

❑ Appendix: (Appendectomy)	❑ Liver: Liver Transplant
❑ Bladder: (Cystectomy)	❑ Liver: Shunt
❑ Breast: Breast Biopsy	❑ Ovaries: (Oophorectomy) Endometriosis
❑ Breast: Lumpectomy ❑ Both ❑ Left ❑ Right	❑ Ovaries: (Oophorectomy) Ovarian Cancer
❑ Breast: Mastectomy ❑ Both ❑ Left ❑ Right	❑ Ovaries: (Oophorectomy) Ovarian Cyst
❑ Colon: (Colectomy) Colon Cancer Resection	❑ Ovaries: Tubal Ligation
❑ Colon: (Colectomy) Diverticulitis or IBD	❑ Pancreas: Pancreatectomy
❑ Colon: Colostomy	❑ Prostate: (Prostatectomy) Prostate Biopsy
❑ Gallbladder: (Cholecystectomy)	❑ Prostate: (Prostatectomy) Prostate Cancer
❑ Heart: Biological Valve Replacement	❑ Prostate: (Prostatectomy) TURP
❑ Heart: Coronary Artery Bypass Surgery	❑ Rectum: APR or low anterior resection
❑ Heart: Heart Transplant	❑ Skin: Basal Cell Carcinoma
❑ Heart: Mechanical Valve Replacement	❑ Skin: Melanoma
❑ Heart: PTCA	❑ Skin: Skin Biopsy
❑ Joint Replacement: Hip ❑ Both ❑ Left ❑ Right	❑ Skin: Squamous Cell Carcinoma
❑ Joint Replacement: Knee ❑ Both ❑ Left ❑ Right	❑ Spleen: (Splenectomy)
❑ Kidney: Kidney Biopsy	❑ Testicles: (Orchiectomy)
❑ Kidney: Kidney Stone Removal	❑ Uterus: (Hysterectomy) Fibroids
❑ Kidney: Kidney Transplant	❑ Uterus: (Hysterectomy) Uterine Cancer
❑ Kidney: Nephrectomy	❑ Uterus: (Hysterectomy) Cervical Cancer
❑ Liver: Hepatectomy	
❑ Other (please list)	
❑ None	

SKIN DISEASE HISTORY (please check all that apply)

❑ Basal Cell Skin Cancer	❑ Actinic Keratoses	❑ Flaking or itchy scalp
❑ Squamous Cell Skin Cancer	❑ Asthma	❑ Hay fever / allergies
❑ Precancerous moles	❑ Blistering sunburns	❑ Poison Ivy
❑ Melanoma	❑ Dry skin	❑ Psoriasis
❑ Acne	❑ Eczema	❑ Cold sores or fever blisters
		❑ Rash from sun exposure
❑ Other (please list)		
❑ None		
Do you wear sunscreen? ❑ Yes ❑ No	If yes, what SPF? _____	
Do you tan in a tanning salon? ❑ Yes ❑ No	If yes, how often? _____	

FAMILY HISTORY

Do you have a family history of Melanoma? ❑ Yes ❑ No If yes, which relative(s)? _____

Skin Cancer (Basal Cell or Squamous Cell) ❑ Yes ❑ No If yes, which relative(s)? _____

Psoriasis ❑ Yes ❑ No If yes, which relative(s)? _____

Eczema ❑ Yes ❑ No If yes, which relative(s)? _____

Other Skin Diseases ❑ Yes ❑ No If yes, which relative(s)? _____

Other Cancers ❑ Yes ❑ No If yes, which relative(s)? _____

CURRENT MEDICATIONS (dose and frequency)

1.	5.
2.	6.
3.	7.
4.	8.

ALLERGIES (please list ALL allergies and reactions)

1.	5.
2.	6.
3.	7.
4.	8.

SOCIAL HISTORY

Tobacco Use:	Alcohol Use:	Drug Use:
❑ Never smoked	❑ Alcohol: none	❑ IV Drug use
❑ Quit: former smoker	❑ Alcohol: less than one drink per day	❑ Other (please list)
❑ Smokes less than daily	❑ Alcohol: 1-2 drinks per day	❑ None
❑ Smokes daily	❑ Alcohol: 3 or more drinks per day	
❑ Chewing tobacco		

❑ Other (please list)

Hobbies: _____

ALERTS: Are you currently experiencing or have you experienced any of the following: (please check all that apply)

❑ Currently pregnant or planning pregnancy	❑ Premedication prior to procedures
❑ Currently breastfeeding	❑ Blood thinner
❑ Allergy to adhesive or latex	❑ Defibrillator
❑ Allergy to lidocaine	❑ Pacemaker
❑ Allergy to topical antibiotic ointments	❑ MRSA
❑ Allergy to betadine/iodine	❑ Immunosuppression
❑ Rapid heartbeat with epinephrine	❑ HIV/AIDS
❑ Artificial heart valve	❑ Hepatitis C or Tuberculosis
❑ Artificial joint(s) within the last 2 years	

❑ Other (please list)

❑ None

I verify that the above information is true and accurate to the best of my knowledge.

Patient or Responsible Party Signature: _____ **Date:** _____

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Cosmetic History Intake Form

PATIENT INFORMATION

Patient Name: Last, First, M.I.	DOB	Age
Reason for today's visit:		
What would you like to accomplish with your visit today?		
What concerns do you have about your skin?		
What brands/products are you currently using on your skin?		

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING: (please check all that apply)

Waxing/Hair Removal ❑ Yes ❑ No Date:_____	Microdermabrasion ❑ Yes ❑ No Date: _____
Sunburn or Heavy/Direct Sun Exposure ❑ Yes ❑ No Date:_____	Do you have a tendency toward redness, rash or hives? ❑ Yes ❑ No
Tanning Bed Exposure ❑ Yes ❑ No Date:_____	Injectable(s) in the last 30 days (Botox etc. or fillers) ❑ Yes ❑ No If yes, please provide details_____
Laser Procedure(s) ❑ Yes ❑ No Date:_____ If yes, what type?_____	Other cosmetic procedure(s)?_____ _____

ARE YOU TAKING/USING ANY OF THE FOLLOWING: (please check all that apply)

❑ Accutane	❑ Tretinoin/Retin-A/Renova
❑ Alpha hydroxy products	❑ Other (please list)
❑ Birth control or hormone therapy	❑ None

I verify that the above information is true and accurate to the best of my knowledge.

Patient or Responsible Party Signature_____**Date**_____