Lakes Dermatology 2704 Enterprise Ave Spirit Lake, IA 51360 Phone: 712-336-2728 Fax: 712-336-2842

Patient's Last Name:______________________ First Name:____________________ Middle Name:_____________

Patient's Date of Birth: _____/_____/__________ Age: ________ Gender: F M

Mailing Address: ______________________________ City:______________________ State:______ Zip:________

Home Phone:___________________Cell Phone: _______________________Work Phone:____________________

Email Address:____

Employer:_______________________________Employer Address:_____________________________________

Marital Status: Single Married Name of Spouse: ______________________________Divorced Separated Widowed

Name of Primary Physician: ________________________ Name of Referring Physician: ______________________

If patient is a minor, please fill out the following:

Name of Parent/Legal Guardian:____

Parent/Legal Guardian Date of Birth:______________________Parent/Legal Guardian SSN:___________________

Parent/Legal Guardian Employer:____

Employer Address:____Employer Phone:_______________

Insurance Information

****We require a copy of the front and back of all insurance cards at the time of service****

Insurance Policy Holder Name:___________________________Policy Holder Date of Birth:____________________

Will this be covered by Worker's Comp? YES NO Approval from/Title: _____________________________________

I, the undersigned guarantor, hereby guarantee full and prompt payment to Lakes Dermatology for all charges made as a result of services rendered for the above-named patient. I agree to pay Lakes Dermatology for said charges upon the failure of said patient, any responsible insurer, or any other person or firm to pay the same when due. The patient is responsible for any legal or court costs required in the collection of any unpaid accounts.

I certify this information tis true and correct to the best of my knowledge. I will notify Lakes Dermatology of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Concerning "divorced" or "custody" arrangements, Lakes Dermatology regards the adult party who signs below as the "Parent or Responsible Party" to be the responsible guarantor for that patient's account in all cases and without exception.

I also understand that it is the responsibility of the custodial party to obtain all referrals and that Lakes Dermatology is not responsible for obtaining referrals.

I have received Lakes Dermatology's notice of privacy practice.

Responsible Party Signature:____ **Date:**_____________________

Medical History-Circle all that apply:

NONE

- Anxiety disorder
- Arthritis
- Asthma
- Atrial Fibrillation (irregular heartbeat)
- Benign prostatic hyperplasia
- Cerebrovascular accident
- Chronic obstructive lung disease
- Coronary arteriosclerosis
- Depression
- Diabetes
- Disease caused by Covid-19
- Elevated blood pressure
- End stage renal disease
- Epilepsy
- Gastroesophageal reflux disease
- Hearing loss
- Human Immunodeficiency Virus Infection (HIV)
- Hypercholesterolemia (high cholesterol)
- Hyperthyroidism
- Hypothyroidism
- Inflammatory disease of the liver
- Leukemia
- Malignant lymphoma
- Malignant tumor of lung
- Malignant tumor of breast
- Malignant tumor of prostate
- Radiation therapy treatment
- Transplantation of bone marrow

Other____

Surgical History-Circle all that apply:

NONE

- Abdominoperineal resection
- Breast biopsy
- Prostate biopsy
- Coronary artery bypass graft
- Kidney transplant
- Excision of basal cell carcinoma
- Excision of melanoma
- Excision of squamous cell carcinoma
- Colostomy
- Tubal Ligation
- Appendectomy
- Mastectomy
- Gall bladder removal
- Liver excision
- Coronary angioplasty
- Tissue graft heart valve replacement
- Liver transplant
- Colectomy (bladder removal surgery)
- Hysterectomy
- Kidney biopsy
- Resection of rectum
- Lumpectomy of breast (left/right/bilateral)
- Mastectomy of breast (left/right/bilateral)
- Mechanical heart valve replacement
- Ovary removal
- Pancreas removal
- Prosthetic arthroplasty of bilateral hips
- Spleen removal
- Surgical biopsy of skin
- Total Kidney removal
- Testicle removal
- Total hip joint replacement (left/right)
- Total knee joint replacement (left right)
- Heart transplant

Other:____

Skin Disease History-circle all that apply:

NONE

- Acne
- Actinic Keratosis
- Asteatosis cutis
- Basal cell carcinoma
- Poison ivy
- Eczema
- H/O: Asthma
- H/O: Hay fever
- Malignant melanoma
- Dry/itchy scalp
- Psoriasis
- Squamous cell carcinoma
- Sunburn of second degree

Other:____

Do you wear sunscreen? YES NO

If yes, what SPF________

Do you tan in a tanning salon? YES NO

Medication List:

Name of medication	Dose	Frequency

Allergies to Medications:____

Smoking History:

Never Smoked

Former Smoker

Smokes Less than Daily

Smokes Daily

Family History:

Melanoma (relationship)____

Heart Disease (relationship)____

Cancer (relationship)____

Diabetes (relationship)____

Have you had an influenza immunization (flu shot) this year? YES NO

Have you had a shingles vaccination? (ages 50 and over) YES NO

Name of Pharmacy and Town:________________________________

If you are 65 or older, please answer the questions below:

Have you had a pneumonia vaccination? YES NO

Do you have a health care proxy in the event you are unable to make your own medical decisions? YES NO

If yes, list their name______________________________

Phone Number______________________

Do you have a living will? YES NO

Which statement(s) best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Communication Form

Patient Name: ____

Date of Birth:____________________

I give permission for the following person(s) to receive information regarding my appointments, medical care and/or release of medical records:

1. Name:______________________Phone Number:________________

   Relationship:__________________________

2. Name:______________________Phone Number:________________

   Relationship:__________________________

3. Name:______________________Phone Number:________________

   Relationship:__________________________

Note: This form of communication will be used as the standard until revoked in writing by the patient.

Patient/Guardian Signature:______________________________________

Date:________________________