DMC
DERMATOLOGY
Mohs & Cosmetics

Indy Chabra, MD, PhD **Patrick Safo, MD, PhD**
Mannix Consolacion, FNP, BC, DCNP **Sarah Aldor, MSN, NP-C** **Lauren E. King, DMSc PA-C**
4715 E. Camp Lowell Dr. Tucson - TMCOne Rincon (Houghton/Drexel/Vail) - SaddleBrooke - Benson Hospital - MHC Marana - Green Valley

Phone: (520) 433-7000 **Fax: (520) 300-8013**
DMCDerm.com

Medical History Form

Patient Name:____________________ Date of birth: ____/____/____ Height:______Weight:______

Primary Care Physician / Referring Provider:____

Pharmacy Name and Location:____

Please list your prescription medications:____

____

Do you have any allergies to medications or to Latex? (Please circle) Yes / No
If yes please list allergies: ____

Do you have a Pacemaker / Defibrillator? Yes / No (If yes, please circle which)

Do you have HBV, HCV, or HIV? Yes / No

Have you ever had any type of skin cancer? Yes / No
If yes, please specify - Basal cell, Squamous cell, or Melanoma?___________________________
Do you have any family history of Melanoma? Yes / No

Do you smoke, vape, or chew tobacco? Yes / No

Are you interested in Cosmetic/Aesthetic Services? Yes / No
- (Treat acne scarring, fine lines, wrinkles, brown or red spots, hair growth, hair loss, Botox, Filler, Lasers)
If **YES** would you like an email or Phone message with **Cosmetic and Aesthetic Services Information** sent to your: Contact Information **on file**: **Yes / No** or to a **Different** email/phone number**:________________**

FEMALES:
Are you currently pregnant? Yes / No
Are you nursing? Yes / No
Are you trying to become pregnant? Yes / No

Patient/Guardian Signature: ___________________________________Date_____________

Relationship to Patient (if not Self):______________________________

Physician/Provider Signature: ________________________________Date _____________

DMC
DERMATOLOGY
Mohs & Cosmetics

Indy Chabra, MD, PhD **Patrick Safo, MD, PhD**
Mannix Consolacion, FNP, BC, DCNP **Sarah Aldor, MSN, NP-C** **Lauren E. King, DMSc PA-C**
4715 E. Camp Lowell Dr. Tucson - TMCOne Rincon (Houghton/Drexel/Vail) - SaddleBrooke - Benson Hospital - MHC Marana - Green Valley

Phone: (520) 433-7000 Fax: (520) 300-8013
DMCDerm.com

Basic Information About You

Patient Name: ________________________________ **DOB**_____/____/______ **SSN:** ______-_____-________

Mailing address:____**City**_____________**State**_______**Zip**________

Primary phone:______________________________ **Ok to leave message? Yes / No**

Secondary phone:___________________________ **Ok to leave message? Yes / No**

Email address: ____**Paperless Billing? Yes / No**
Appointment reminder preference: ☐ **Text** ☐ **Email**

Emergency Contact:___________________________________**Relation:**_____________**Phone:**________________

Primary Insurance ___________________________ **ID#** _________________**Group #**_____________

Secondary Insurance _________________________**ID#**_________________ **Group #**_____________

Employment status: (Please circle) FT / PT / Retired / Unemployed / Student FT / PT

Marital status: (Please circle) Single / Divorced / Widowed / Married

Patient/Guardian Signature:____**Date:**__________

Please complete this section ONLY if patient is NOT insurance subscriber or is under 18 years old

Parent/Guardian or Responsible party

Parent-Guardian /Subscriber Name:______________________________**Date of Birth**____/___/______**Relation to patient:**______________

Address:____**City**_______________________**State**_________**Zip**__________

Primary Phone:_____________________________________ **Secondary Phone:**___________________________________

The Notice of privacy practices for DMC Dermatology and Mohs is available at the front reception desk. Please ask if you would like to obtain a copy

Copyright © 2022 DMC Dermatology and Mohs, LLC, All Rights Reserved.

DMC DERMATOLOGY
Mohs & Cosmetics

Indy Chabra, MD, PhD **Patrick Safo, MD, PhD**
Mannix Consolacion, FNP, BC, DCNP **Sarah Aldor, MSN, NP-C** **Lauren E. King, DMSc PA-C**
4715 E. Camp Lowell Dr. Tucson - TMCOne Rincon (Houghton/Drexel/Vail) - SaddleBrooke - Benson Hospital - MHC Marana - Green Valley

Phone: (520) 433-7000 **Fax: (520) 300-8013**
DMCDerm.com

Do You Want Your Medical Information Sent to Anyone?

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with State and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

I **authorize DMC Dermatology & Mohs** to send out my medical information to:

Primary Care Provider or Referring Provider Name: ______________________________

Fax of physician (optional):____________________

Any and all health information may be sent **Excluding**; Mental health, drug and alcohol abuse, and HIV/AIDS which must be specifically requested below.
According to State and Federal law, re-disclosure of health information involving patients treated for drug and alcohol abuse, mental health, and HIV/AIDS, is prohibited unless disclosure is expressly permitted by consent of the person to whom it pertains or as otherwise permitted by law.

I also **specifically** agree to have my medical information sent regarding:

- ❏ My mental health
- ❏ Drug and alcohol abuse
- ❏ HIV/AIDS

- I understand that if a person or entity that receives the information is not a health-care provider or health plan covered by the federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations.
- I understand that I may refuse to sign this Authorization and that my refusal to sign will not effect the use or disclosure of my health information for purposes of treatment, payment and health care operations.
- I understand that I have the right to inspect the disclosed information at any time. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health-care provider or record keeper.
- A photocopy, or exact reproduction of this signed authorization, shall have the same force and effect as the original.
- **I understand that this authorization is good for one year from the date of signature.**
- **I understand that I may request a copy of this document at any time.**

I hereby authorize the release of information as indicated above.

Print Patient Name:____ **Date of Birth_____________________**

(If Not Self) Print Guardian Name and Relationship to Patient:_____________________________________

Patient (or Guardian) SIGNATURE:______________________________ **Date:___________________**

Copyright © 2022 DMC Dermatology and Mohs, LLC, All Rights Reserved.