Searcy Dermatology, P. A.
1903 E. Beebe-Capps Expy - Searcy, AR 72143-6973
Phone: (501) 279-3838 • Fax:

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Mailing Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Race & Ethnicity _____ Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Phone Number: _____ ☐ Home ☐ Cell Alt Number: _____ ☐ Home ☐ Cell Would you like a text reminder for your appt.? Y/N

Preferred Name: _____ Employment Status: ☐ Employed ☐ Student ☐ Other _____

E-Mail Address: _____ Employer Name & Phone #: _____

Responsible Party Information For Those Under 18 Years of Age

Name: _____ Date of Birth: _____

Mailing Address _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Policies

Please give your insurance card and photo id to the receptionist to copy.

All co-pays are due at the time of service.

If you do not have your insurance card, you will be considered "cash pay" and payment is due today.

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Authorization to Disclose Health Information

I authorize Searcy Dermatology, P.A. to use and/or disclose my health information relating to my dermatology consultation(s) and procedure(s) to any healthcare provider involved in my current treatment/diagnosis.

I authorize the following individual(s) complete access to my health information and account records:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Primary Care Physician & Pharmacy Information

Primary Care Physician _____ Pharmacy _____

Street Address & City _____

Referral Information

☐ By a Doctor _____ ☐ By a Patient _____ ☐ Other _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I acknowledge and agree that a copy of the Searcy Dermatology, P. A. Privacy Practices were provided to me or made available for viewing.

I hereby assign, transfer, and set over to Searcy Dermatology, P. A. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insuranc

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

PRESENT/PAST MEDICAL HISTORY: Please circle the following which you have had or have at the present

Heart Failure	Heart Disease	Heart Murmur	Heart Surgery
Mitrial Valve Prolapse	Artificial Heart Valve	High Blood Pressure	Anemia
Tuberculosis	Asthma	Kidney Problems	Sinus Trouble
Hives	Lupus	Thyroid	Arthritis
Depression	HIV Infection	Hepatitis	Liver Disease
Hemophilia	Diabetes	Bleeding Problems	Healing Problems
Keloids	Artificial Joints	Hysterectomy	
Sexually Transmitted Disease		Other_____	

ALLERGIES: **(Circle if apply and list type of reaction)** **NO KNOWN DRUG ALLERGIES_____**

Penicillin_____	Sulfa_____	Codeine_____
Tetracycline _____	Erythromycin_____	Aspirin_____
Lidocaine _____	Novocaine _____	Tape_____
Latex_____	Other_____	

CURRENT MEDICATIONS: (or provide a list to be copied)

_____
_____
_____
_____
_____

Do you require Pre-medication prior to surgery due to artificial joints or heart valves?

No_____ Yes_____ List Drug(s)_____

SOCIAL HISTORY:

Tobacco Use: Current_____ Frequency_____
Past _____
Never _____

Alcohol Use: Current_____ Frequency_____
Past _____
Never _____

Influenza Vaccine: YES___ NO___ DATE_____ ***Pneumonia Vaccine***: YES___ NO___ DATE_____

REVIEW OF SYSTEMS: (check those symptoms that you are currently experiencing)

___Fever	___Itching	___Hair Loss	___Leg Swelling (Edema)
___Asthma	___Arthritis	___Chills	___Seasonal Allergies
___Fever Blisters	___Enlarging Lymph Nodes		

FAMILY HISTORY:

Do any members of your family have: _____Skin Cancer _____Melanoma

FEMALES ONLY:

Currently pregnant or could be pregnant: YES / NO Currently taking oral contraceptives: YES /NO

History of mammogram: YES / NO If yes, date of last mammogram_____