Eyre Dermatology Clinic
Russell W. Eyre, M.D. & Steven P. Eyre, M.D.

486 W 800 N Suite 201
Orem, UT 84057
Phone: 801.431.0300
Fax: 801.431.0312

PATIENT INFORMATION

PATIENT NAME: LAST FIRST M.I			SOCIAL SECURITY NUMBER
MAILING ADDRESS STREET OR PO BOX APT		DATE OF BIRTH	GENDER: FEMALE ☐ MALE ☐
CITY STATE ZIP	HOME PHONE	CELL PHONE	WORK
EMAIL	MARITAL STATUS: SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOW ☐ PARTNER ☐		
RACE: WHITE ☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ PACIFIC ISLANDER ☐ OTHER ☐	ETHNICITY: HISPANIC ☐ NON-HISPANIC ☐	PREFERRED LANGUAGE:	
2ND/ SEASONAL ADDRESS STREET OR PO BOX APT CITY STATE ZIP			
PREFERRED PHARMACY: PHONE: CITY: ZIP: FAX:			

INSURANCE POLICY HOLDER

IF POLICY HOLDER IS DIFFERENT FROM PATIENT THEN PLEASE COMPLETE THIS SECTION

FULL NAME	SOCIAL SECURITY NUMBER
MAILING ADDRESS STREET OR PO BOX APT	DATE OF BIRTH
CITY STATE ZIP	PREFERRED PHONE NUMBER
PATIENT RELATIONSHIP TO RESPONSIBLE PARTY	EMAIL ADDRESS

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOFITY:	PHONE:

MEDICAL RECORD DISCLOSURE

I authorize Eyre Dermatology Clinic to discuss the following aspects of my care with the following individual(s):

NAME:	RELATIONSHIP:	NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:	NAME:	RELATIONSHIP:

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF THE CARD TO THE RECEPTIONIST

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME	INSURANCE NAME
POLICY / ID#	POLICY / ID#
GROUP / ACCOUNT #	GROUP / ACCOUNT #
POLICYHOLDERS NAME	POLICYHOLDERS NAME
DATE OF BIRTH SSN	DATE OF BIRTH SSN
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT

EYRE DERMATOLOGY CLINIC

PATIENT NAME	DOB

PAST MEDICAL HISTORY
PLEASE CHECK ALL THAT APPLY

☐ NONE	☐ Diabetes	☐ Leukemia
☐ Anxiety	☐ High blood pressure	☐ Lymphoma
☐ Arthritis	☐ End stage renal disease	☐ Lung cancer
☐ Asthma	☐ Seizures	☐ Breast cancer
☐ Atrial Fibrillation	☐ GERD (acid reflux)	☐ Colon cancer
☐ Enlarged prostate	☐ Hearing loss	☐ Prostate cancer
☐ Bleeds easily	☐ HIV / AIDS	☐ Radiation treatment
☐ Stroke	☐ High Cholesterol	☐ Bone marrow transplant
☐ COPD	☐ Thyroid problems	☐ Other_____
☐ Coronary Artery Disease	☐ Immunosuppressed	_____
☐ Depression	☐ Hepatitis	_____

PAST SURGICAL HISTORY
PLEASE CHECK ALL THAT APPLY

☐ NONE	☐ Liver excision	☐ Kidney stones
☐ Replacement of both knees	☐ Angioplasty	☐ Liver shunt
☐ Breast biopsy	☐ Heart valve replacement	☐Prostate removal
☐ Prostate biopsy	☐ Bladder removal	☐ Hip replacement
☐ Coronary artery bypass	☐ Prostate removal	☐ Spleen removal
☐ Kidney transplant	☐ Hysterectomy	☐ Skin biopsy
☐ Basal cell carcinoma removal	☐ Kidney biopsy	☐ Kidney removal
☐ Melanoma removal	☐ Breast lump removal	☐ Testicle removal
☐ Squamous cell removal	☐ Removal of left breast	☐ Heart transplant
☐ Tubal ligation	☐ Removal of right breast	☐ Liver transplant
☐ Removal of appendix	☐ Heart valve replacement (mechanical)	☐ Other
☐ Mastectomy (both breasts)	☐ Ovary removal	_____
☐ Gallbladder removed	☐ Pancreas removal	_____

SKIN DISEASE HISTORY
PLEASE CHECK ALL THAT APPLY

☐ NONE	☐ Poison Ivy	☐ Melanoma
☐ Acne	☐ Atypical or dysplastic mole	☐ Itchy scalp
☐ Actinic keratosis (pre-cancerous)	☐ Eczema	☐Psoriasis
☐ Dry skin	☐ History of asthma	☐Squamous cell carcinoma
☐ Basal cell skin cancer	☐ History of hay fever/allergies	☐Other _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes what SPF? _____
Do you tan in a tanning salon? ☐Yes ☐No
Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes which relative(s)? _____

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NAME:	DOB:

IT IS OK TO HAVE MY CURRENT MEDICATION LIST TRANSFERRED FROM THE PHARMACY
☐YES ☐NO

MEDICATIONS

PLEASE LIST ALL CURRENT **PRESCRIPTION** MEDICATIONS
☐NONE

Medication Dose (strength, frequency)	Medication Dose (strength, frequency)
1.	5.
2.	6.
3.	7.
4.	8.
9.	10.
11.	12.
13.	14.

MEDICATION ALLERGIES

PLEASE LIST ALL MEDICATION ALLERGIES
☐ NONE

1.	2.
3.	4.
5.	6.

SOCIAL HISTORY

Smoking Habits:

☐ never smoker
☐ current every day smoker
☐ current someday smoker
☐ former smoker

Alcohol Intake:

☐ None
☐Less than 1 drink per day
☐ 1-2 drinks per day
☐ 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

EYRE DERMATOLOGY CLINIC

NAME:	DOB:

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

☐ changing lesion	☐ problems with bleeding	☐ problems with healing
☐ night sweats	☐ sore throat	☐ rash
☐ thyroid problems	☐ unintentional weight loss	☐ blurry vision
☐ neck stiffness	☐ problems with scarring	☐ abdominal pain
☐ seizures	☐ wheezing	☐ bloody stool
☐ cough	☐ fever or chills	☐ joint aches
☐ shortness of breath	☐ chest pain	☐ headaches
☐ muscle weakness	☐ hay fever	☐ anxiety
☐ bloody urine	☐ immunosuppression	☐ depression
		☐ dizziness

ALERTS

☐ allergy to adhesive	☐ defibrillator
☐ latex allergy	☐ MRSA
☐ allergy to lidocaine	☐ pacemaker
☐ allergy to topical antibiotic ointment	☐ premedication prior to procedure
☐ allergy to oral antibiotic	☐ rapid heart beat with epinephrine
☐ artificial heart valve	☐ pregnancy or planning a pregnancy
☐ artificial joints in the past 2 years	☐ yeast infection with antibiotics
☐ blood thinners	☐ Other_____

REASON FOR SEEING THE PHYSICIAN TODAY

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that while Eyre Dermatology Clinic contracts with many insurance companies, it is MY responsibility to verify with my insurance plan that the physician I am seeing is a participating provider. I further understand that Eyre Dermatology Clinic will bill my insurance as a courtesy to me. I authorize payment of medical benefits to Eyre Dermatology Clinic and physicians. If, however, my insurance does not cover the services, I will be financially responsible for the services rendered. I hereby authorize Eyre Dermatology Clinic to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. It is my responsibility to provide Eyre Dermatology Clinic with correct and current information. I understand that co-pays are due at the time of service. If my account becomes more than 90 days past due, the account will automatically be turned over to a collections agency, and additional charges will be assessed.
Blood tests and pathology consults are not billed from Eyre Dermatology Clinic. They are billed from the facilities that the specimens are sent to. These facilities will bill your insurance for tests ordered, but you may still receive a bill for deductibles and co-pays as required by your insurance. By signing this, I authorize Eyre Dermatology Clinic to provide these facilities with the necessary information to process claims on my behalf.
I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Eyre Dermatology Clinic to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my Eyre Dermatology Clinic to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. I have received a copy of the HIPAA policy. I authorize treatment.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:	DATE