Goodless Dermatology
Quality skincare for your entire family

Please verify that the following information is current, correct and fill in anything that is left blank. Thank you.

Today's Date: Demographics (1 of 2)

Patient Information:

Name:_____

Date of Birth: _____ Circle One: Male Female

Address _____

Email:_____

Contact Information:

MAY WE LEAVE DETAILED MESSAGES
(i.e. Appointments, Billing, Results, etc.)?

Home #: (____) _____	YES	NO	N/A
Mobile #: (____) _____	YES	NO	N/A
Work #: (____) _____	YES	NO	N/A
Would you like to receive Text Messages?	YES	NO	N/A

Emergency Contact Information:

Can we discuss your Health Care Information with the person listed below? YES NO

_____

First M.I. Last Relationship Contact #

Please list any medical providers you would like to authorize to have access to your medical records. These records will only be released upon your verbal request. You may revoke this authorization in writing at any time. By completing this section, you are authorizing Goodless Dermatology to release your medical record (including laboratory test results) to the Provider(s) listed.

Primary Care Physician: _____ Phone #: _____

Address: _____ Fax #: _____

Other Physician: _____ Phone #: _____

Address: _____ Fax #: _____

Were you referred to our office by a physician? Please circle: YES No

If yes, Referring Physician: _____ Phone #: _____

Address: _____ Fax#: _____

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Today's Date: Demographics (2 of 2)

Patient's Name:_____ **Date of Birth:** _____

Affordable Healthcare Act Questionnaire:

Race (Please circle only one)

I choose not to specify American Indian/Alaskan Native Asian White/Caucasian

Native Hawaiian/Other Pacific Island Black/African American Other: _____

Ethnicity (Please circle only one)

I choose not to specify Not Hispanic or Latino Hispanic or Latino

Preferred Language (Please circle only one)

I choose not to specify English Spanish American Sign Language Other: _____

Privacy Acknowledgment:

_____ **Initials**

We are required to protect your privacy
Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is available on our website and/or is furnished.

_____ **Initials**

We request all patients present a valid photo ID at each visit, unless we have it on file.
Your cooperation with HIPAA requirement is designed to protect your identity from misuse.

_____ **Initials**

Patients may revoke or change any provided authorizations at any time.
Please refer to our NPP for more details.

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Today's Date:

Patient's Name:_____ **Date of Birth:**_____

Social History:

Smoking Status: (Please circle one) Current smoker Former smoker Never smoked

Have you received an influenza immunization? YES NO

Have you received the COVID-19 vaccine? YES NO

If yes, what is the name of the vaccine you received?

Moderna ____ Pfizer_____ J&J _____ Don't know_____

Have you received a Pneumonia vaccination? YES NO

Do you have any of the following, if you do not, please circle none:

Please furnish a copy of legal documents to Goodless Dermatology, if necessary.

☐ None ☐ Living Will ☐ A Health Care Proxy

Health care proxy name and contact #: _____

Which statement best reflects your wishes on advanced care recommendations?

Please select one of the following:

☐ Full Code: I wish to have full cardiopulmonary resuscitation efforts to be made.

☐ Do Not Intubate: I do NOT wish to have a breathing tube, even if it is required for life saving measures.

☐ Do Not Resuscitate: In the event that my heart was to stop, I do NOT wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is required for life saving measures.