Patient Information

Name___________________________________ Date of Birth______________________ Age ________

Birth Sex: M or F Identified Gender_________________ Race/Ethnicity_________________________

Marital Status_______________________ Occupation____

Address____________________________________ City____________________ State_____ Zip_______

Cell Phone________________ Home Phone_________________ Email______________________________

How did you hear about us? ____

Insurance Information

Primary Insurance ____

Address ____

Policy No.______________________________________ Group No. _______________________________

Secondary Insurance____

Address____

Policy No._____________________________________ Group No. ________________________________

Communication Authorization

I, ____________________________________ authorize the staff of Pamela S. Kennedy, M.D. to notify me of my diagnostic/lab results over the telephone by either of the following:

____ Speak **directly** with myself or authorized person ***OR*** ____ Okay to leave a voicemail message

List any other persons authorized to accept results or make changes to appointments:

Name________________________ Relationship_____________________ Phone_____________________

Name________________________ Relationship_____________________ Phone_____________________

Name________________________ Relationship_____________________ Phone_____________________

Patient History

Name________________________ Date of Birth______________ Height_______ Weight_______

Reason for today's visit ____

Primary Care Physician (PCP) ____

Pharmacy__________________________ Address ____

Please list all Medications:
Please list all Allergies:

Check if you have any of the following:

Pacemaker		Blood Thinners/Aspirin		Irregular Heartbeat	
Heal: Thick Scar		Joint Pain		High Blood Pressure	
Seizures		Hay Fever		Hepatitis	
Pregnant/Planning/Breastfeeding		Asthma		Artificial Valves/Joints	
Diabetes		Thyroid Disorder: Hyper/Hypo		Immune Deficiency/HIV	
Depression		Liver Disease		GI/GERD (Reflux)	

Other (please explain)____

Do **you** have a history of **skin cancer**? Yes or No If yes, which type?___________________________

Do you have a **family history** of Melanoma? Yes or No If yes, relation?_________________________

Do you smoke cigarettes? Yes or No Do you consume alcohol? Yes or No

For Females only:

Are you having menstrual cycles? Yes or No Date of last menstrual cycle ______________________

Have you had a hysterectomy? Yes or No

Are you sexually active? Yes or No Form of Contraception ______________________________

- By signing below, I certify all information is true and correct to the best of my knowledge.
- I hereby authorize the release of medical information necessary to file a claim with my insurance company, if applicable. I understand I am financially responsible for *any balance not covered by my insurance carrier* once a claim is filed. *Please speak to your provider *before* a procedure is performed should you have a question regarding procedure cost.

Signature____ Date _______________________