Wendy D. Schuen, M.D.
5040 Forest Drive, Suite 150
New Albany, OH 43054
Phone: (614) 775-9000 • Fax: (614) 775-9002

New Patient Information
PLEASE PRINT

Office Use Only

Acct # ______
Checked ID ☐

PATIENT INFORMATION

NAME (LAST)	(FIRST)	(MIDDLE INITIAL)	What do you prefer to be called?

SEX M F	AGE	DATE OF BIRTH	SOCIAL SECURITY NO.	MARITAL STATUS SIN MAR WID	RACE

ADDRESS (STREET # AND NAME)	(CITY)	(STATE)	(ZIP)	HOME PHONE	CELL PHONE

PATIENT'S (OR PARENT'S) EMPLOYER	OCCUPATION	WORK PHONE

SPOUSE NAME	SPOUSE EMPLOYER	OCCUPATION	WORK PHONE

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)	(LAST)	(FIRST)	(MIDDLE INITIAL)

RESPONSIBLE PARTY'S ADDRESS	(STREET #)	(STREET NAME)	(CITY)	(STATE)	(ZIP)

I WAS REFERRED BY:	E-MAIL ADDRESS:

EMERGENCY CONTACT	(NAME)	(PHONE)

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CO. NAME		
SUBSCRIBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT		

SECONDARY INSURANCE COVERAGE

INSURANCE CO. NAME		
SUBSCRIBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT		

PREFERRED PHARMACY	PHONE NO.

OVER

AUTHORIZATIONS

1. Consent for Treatment: I hereby consent to and authorize all treatments by Wendy D. Schuen, M.D.

2. If I am self-pay or carry insurance that Wendy D. Schuen, M.D. is not contracted with, I understand that payment is expected at the time of service and it is my responsibility to file the claim with my insurance carrier.

3. If Wendy D. Schuen, M.D. is contracted with my insurance company, I request that payments of authorized benefits be made directly to her. I authorize release to my insurance carrier(s) any medical information about me needed to determine these benefits. Regardless of my insurance benefits, I understand I am financially responsible for all charges. Any applicable co-pays are due at the time of service.

4. If I am unable to keep a scheduled appointment, I understand that I need to notify the office at least 24 hours in advance or I may be charged a minimum office charge of $25. I understand this charge is not covered by insurance plans.

5. I have received a copy of Advanced Dermatology & Skin Surgery Center's Notice of Privacy Practices.

PRINT NAME ________________________________ DATE _________________

SIGNATURE ____
(Parental or guardian signature required if patient is under 18 years of age.)

I have reviewed all information included on this form and verify it to be current and accurate.

Date	Signature
____________________	____
____________________	____
____________________	____
____________________	____
____________________	____

Name ____

MEDICAL HISTORY

DRUG ALLERGIES: *(List type of reaction)*

- ☐ Anesthetics ______________________________
- ☐ Codeine ________________________________
- ☐ Penicillin _______________________________
- ☐ Tetracycline _____________________________
- ☐ Aspirin __________________________________
- ☐ Erythromycin ____________________________
- ☐ Sulfa ___________________________________
- ☐ Others, *please list* ________________________

NON-DRUG ALLERGIES: *(For example, IVP dye, food allergies, tape allergies; include type of reaction)*

____

CURRENT MEDICATIONS: *(Include all prescribed and over-the-counter drugs)*

____

____

PRE-MEDICATION REQUIRED PRIOR TO SURGERY? ___ no ___ yes

MEDICAL HISTORY: (Use **C** if current, **P** if past; be sure to check all that apply)

___ anemia
___ arthritis
___ asthma
___ back problems
___ bleeding, excessive
___ blood clots
___ breathing disorder
___ bruise easily
___ cancer
___ cataracts
___ colon/intestinal disorder
___ convulsions/seizures
___ dental/gum problems
___ depression
___ diabetes
___ eczema
___ epilepsy
___ fainting spells
___ fibromyalgia
___ glaucoma
___ hair loss
___ hay fever
___ headaches, chronic
___ heart problems
___ hepatitis
___ herpes simplex (cold sores)
___ herpes zoster (shingles)
___ high blood pressure
___ HIV disease
___ infections, chronic
___ kidney disease
___ liver disease
___ lung disease
___ lupus
___ mitral valve prolapse
___ nervous condition
___ neurological problems
___ pacemaker
___ psoriasis
___ psychiatric consultation
___ rheumatic fever
___ risk factors for HIV
___ scarring/keloids
___ STD/venereal disease
___ stroke
___ thyroid disease
___ tuberculosis
___ ulcers
___ varicose veins
___ wound healing difficulty
___ high cholesterol/triglycerides

List any other medical diseases or conditions______________________________________

____

SURGICAL HISTORY: *(List type and date)*

____

____

Have you ever had a malignant melanoma? ___ yes ___ no
Date _______________ Location on body ______________________________

Have you ever had a non-melanoma skin cancer (such as Basal Cell or Squamous Cell Carcinoma)? ___ yes ___ no
Date ______________ Location on body __________________________

Have you ever had an atypical/abnormal mole removed? ___ yes ___ no
Date ______________ Location on body __________________________

Do you smoke now or have you in the past? ___ yes ___ no How many packs per day? ___________________
How many years? _________________

Do you drink alcohol? ___ yes ___ no How much? ____________________________________

Do you wear contact lenses? ___ yes ___ no

Do you use tanning beds? ___ yes ___ no Frequency? ___________________ How many years? ________

Do you have a history of 3 or more severe sunburns? ___yes ___ no Location on body ____________________

Have you ever had ultraviolet light treatment for acne? ___ yes ___ no

Have your ever taken Accutane? ___ yes ___ no Date? _____________ Dosage? _____________
How many months? ______________

Females only:
___ chronic vaginal infections ___ currently taking oral contraceptives ___ currently pregnant ___ currently nursing
___ possibly pregnant ___ trying to conceive Date of last menses_____________

Patients under 16 years of age: Are vaccinations current? ___ yes ___ no

FAMILY HISTORY:

Check the following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative (specify)	Disease	Mother	Father	Blood Relative (specify)
Allergies	☐	☐	☐ ____________	High blood Pressure	☐	☐	☐ ____________
Asthma	☐	☐	☐ ____________	Lung Disease	☐	☐	☐ ____________
Diabetes	☐	☐	☐ ____________	Malignant Melanoma	☐	☐	☐ ____________
Eczema	☐	☐	☐ ____________	Psoriasis	☐	☐	☐ ____________
Excessive Bleeding	☐	☐	☐ ____________	Psychiatric/Nerve Problems	☐	☐	☐ ____________
Excessive Bruising	☐	☐	☐ ____________	Skin Cancer	☐	☐	☐ ____________
Excessive Scarring	☐	☐	☐ ____________	Thyroid Problems	☐	☐	☐ ____________
Hayfever	☐	☐	☐ ____________	Tuberculosis	☐	☐	☐ ____________
Heart Disease	☐	☐	☐ ____________	Other Cancers	☐	☐	☐ ____________

Family doctor ____ Phone _________________

Address ____

____

May we contact him/her in regard to any medical problems that may arise? ___ yes ___ no

Signature ______________________________________ **Date** __________________________

Other family members who are patients in this office ____