Deanna Brown, MD FAAD
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Cara Hennings, MD FAAD
4bridgesderm.com

FOUR BRIDGES
DERMATOLOGY & COSMETICS

1247 Riverfront Parkway, Suite 205
Chattanooga, TN 37402
Phone: (423) 521-4232
Fax: (423) 521-4235

Intake and History Form

Name: _____ Date: _____

Street Address: _____

City/State: _____ Zip: _____ Email Address: _____

Phone Number (home): _____ Phone Number (mobile): _____

Date of Birth: _____ Gender: _____ SSN: _____

Emergency Contact: _____ Phone: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

(For minors) Name of responsible party : _____ Relationship to patient: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Cardholder's Name: _____ Cardholder's Name: _____

Insured SSN: _____ DOB: _____ Insured SSN: _____ DOB: _____

Group #: _____ Policy #: _____ Group #: _____ Policy #: _____

Employer: _____ Employer: _____

I authorize the release of medical or other information about me to the listed insurance provider(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. **Copays are due at time of service.** All accounts should be paid within 90 (ninety) days of insurance being posted to prevent further action. I/we agree to pay any collection or attorney fees owed in addition to court costs if charges are not paid within the terms stated above and legal action is necessary to obtain collection.
I/we give permission for my/our minor child to receive medical attention.
I/we certify that I/we have read all of the above and the information given is true.
I understand that I may be charged a no-show fee of $50 for an office visit and $100 for a procedure visit if I miss or cancel my appointment with less than 48 hours notice.

Patient/Guarantor Signature: _____ Date: _____

Please bring your current insurance card, photo ID, and a copy of this paperwork to your appointment. We recommend arriving at least 10 minutes early to ensure you have plenty of time to check in.

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Reason for your visit today:_____

Name of Person/Provider who referred you: _____

Primary Care Physician: _____

Preferred Pharmacy

Name: _____

Phone Number: _____ City or Zip Code: _____

Primary Care Provider:

Facility: _____ City:_____ State: _____

Provider Name: _____ Provider Phone Number: _____

Past Medical History (select all applicable)

Arthritis	Atrial Fibrillation	Prostate cancer
COPD	Stroke	Non-alcoholic fatty liver
Depression	Congestive Heart Failure	Polycystic ovarian syndrome
Diabetes	DVT–Deep vein thrombosis	Systemic lupus erythematosus
End-stage kidney disease	COVID 19 infection	Bone marrow transplant
Hypertension	Epilepsy	Other:_____
HIV infection	Migraines	
High Cholesterol	Hearing loss	_____
Leukemia	Hyperthyroidism	
Lymphoma	Hypothyroidism	_____
Cancer of Colon	Hepatitis	
Anxiety	Breast cancer	_____
Asthma	Lung cancer	

Past Surgical History (select all applicable)

Colectomy	Lumpectomy of breast	Left hip replacement
Coronary artery bypass graft	Mastectomy of left breast	Left knee replacement
Kidney transplant	Mastectomy of right breast	Right hip replacement
Colostomy	Mechanical heart valve replacement	Right knee replacement
Tubal ligation	Oophorectomy	Heart transplantation
Appendectomy	Prostatectomy	Liver transplantation

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Cholecystectomy | Splenectomy | Other: _____

Tissue graft heart valve replacement | Total nephrectomy

Hysterectomy | Total orchidectomy | _____

Skin Disease History (select all applicable)

Acne | Actinic keratosis | Basal cell carcinoma

Dysplastic/atypical nevus | Eczema | History of asthma

History of hay fever/allergies | Cold sores | Melanoma

Psoriasis | Rosacea | Seborrheic dermatitis

Squamous cell carcinoma | Blistering sunburn | Other: _____

Do you wear sunscreen? Yes No SPF_____

Do you tan in a tanning bed? Yes No

Family history of melanoma Yes No Relation_____

Social History

Do you smoke? Yes _____packs per day Former smoker _____ Never smoked

Do you consume alcohol? Yes _____drinks per day No

Do you use illicit drugs? Yes No

Do you feel safe at home? Yes No

Occupation/Workplace_____

Allergies (please list type of reaction, i.e. rash, hives, anaphylaxis, etc)

_____

_____

Medications (including over-the-counter):

Please include dose and frequency for all medications. Or, attach a current med list.

_____

_____

_____

_____

_____

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Review of Systems:

Pregnant or planning a pregnancy	Yes	No	Premedication prior to procedures	Yes	No
Blood thinners	Yes	No	Rapid heart beat with epinephrine	Yes	No
History of MRSA	Yes	No	Immunosuppression	Yes	No
History of HIV infection	Yes	No	Fainting with procedures	Yes	No
History of Hepatitis B infection	Yes	No			
History of Hepatitis C infection	Yes	No	Fever or chills	Yes	No
Artificial heart valve	Yes	No	Sore throat	Yes	No
Artificial joints in the last 2 years	Yes	No	Cough	Yes	No
Defibrillator	Yes	No	Anxiety	Yes	No
Pacemaker	Yes	No	Shortness of breath	Yes	No
Allergy to adhesive	Yes	No	Problems with bleeding	Yes	No
Allergy to lidocaine	Yes	No	Hypertrophic/keloid scarring	Yes	No
Allergy to antibiotic ointment	Yes	No	Rash	Yes	No
Allergy to latex	Yes	No			

Have you received a Flu Shot within the last year? Yes No

Have you received the Pneumonia Vaccination within the last 10 years? Yes No

Authorization and Privacy Notice

In an effort to protect each person's privacy, 4BDC sta are not allowed to give information on any patient, whether by phone or in person, without the written permission from the patient. We will not allow a person other than yourself to pick up medical records, test results, disability forms, prescriptions, etc., unless prior written consent is obtained from you, the patient or responsible party.

Please specify the people you are giving written permission for:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Do we have your permission to call your home/work/cell to discuss appointments, scheduling of tests and/or procedures as well as results of tests and/or procedures? **Yes** (specify preferred #) _____ **No**

May we leave a message at your home to persons other than yourself and/or on an answering machine to call our o ce? **Yes** **No**

I acknowledge receiving/being offered today a copy of the Provider's Notice of Privacy Policies. I may request a copy at the front desk or view it on 4bridgesderm.com. By signing below, I am authorizing the practice to disclose my protected health information to the persons I have listed above or to other health care providers involved in my medical treatment. I understand my rights and how to revoke this permission as described in the Notice of Privacy Practices offered to me by the practice.

Patient/Guarantor Signature: _____ **Date:** _____