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Are you currently under hospice care? Yes No (please circle)

Updated (08/25/25)

MCCOMB SKIN & AESTHETICS PATIENT INFORMATION

Name: _____ _____ _____
Last First Middle

Preferred Name: _____ **Social Security #** _____ **(required)**

Date of Birth: _____ **Gender: (please circle) Male/Female**

Marital status: (please circle) Married Widowed Divorced Single **Primary Language:** _____

Race: (please circle) American Indian or Alaska Native / Asian / African American / Caucasian / Pacific Islander or Native Hawaiian / Other

Ethnicity: (please circle) Hispanic / Not Hispanic **Patient Email:** _____

Mailing Address: _____ _____ _____ _____
Street/P.O. Box City State Zip

Preferred Phone Number (please circle) Home Phone: _____ **Cell Phone:** _____

Circle Preference for appointment reminders: Text Phone Call

Employment: (please circle) Child / Student / Employed / Retired / Unemployed

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Please list person(s) with whom we may leave messages regarding your Healthcare if we are unable to reach you by phone. (Example: biopsy results, pathology reports, lab reports, prescription requests etc.)
_____
_____
_____

Primary Insurance: _____
Policy Holder Name: _____
Relationship of policy holder to patient: _____
Policy Holder's date of birth: _____
Policy Holder's address and phone # *(if different from patient)*
_____

Secondary Insurance: _____
Policy Holder Name: _____
Relationship of policy holder to patient: _____
Policy Holder's date of birth: _____
Insured's address and phone # *(if different from patient)*
_____

Emergency Contact: (Someone living outside the household) Name: _____ **Phone:** _____

Family member(s) who are patients of McComb Skin & Aesthetics: _____

Financially responsible party *(if different from patient)*:

Name: _____ Address: _____ **DOB:** _____

Phone: _____ Social Security #: _____ Relationship to patient: _____

McComb Skin & Aesthetics participates with Blue Cross Blue Shield, MS State Employee Insurance, Tricare Standard, Medicare, Medigap (supplement) policies, and United Healthcare. <u>If we do not participate with your insurance company, payment must be made at the time of service.</u> ***If for any reason my account is placed in collections, I agree to pay all cost of collections including but not limited to collection cost, attorneys' fees, and court costs.***

Patient signature: _____ **Date:** _____

McCOMB SKIN
& AESTHETICS

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGE FORM

I am a patient of McComb Skin & Aesthetics. I hereby acknowledge receipt of McComb Skin & Aesthetics Notice of Privacy Practices.

Patient Name [please print] : _____

Signature: _____

Date: _____

OR- If the patient is under the age of 18:

I am a parent or legal guardian of _____.

[print patient name]

I hereby acknowledge receipt of McComb Skin & Aesthetics Notice of Privacy Practices with respect to the patient.

Patient Name [please print]: _____

Relationship to patient: _____

Signature: _____

Date: _____

Erik Soine, MD • Rebecca Soine, MD • Heather Newlon, MD • Charly Schmidt, FNP-C
McComb Skin & E, P.A.

Date: _____ **Chart:** _____

Name: _____ **Date of Birth:** _____

Why have you come to see the doctor today? _____

_____

May we leave a detailed message on your preferred phone number? YES ☐ NO ☐

Who is your Primary Care Doctor? _____ Preferred Pharmacy: _____

Past Medical History

Have you ever had:	YES	NO		YES	NO
Alzheimer's	☐	☐	Hearing Loss	☐	☐
Anxiety	☐	☐	Heart Attack	☐	☐
Arthritis, Specify (_____)	☐	☐	Hepatitis, Specify(_____)	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Atrial fibrillation (Irregular Heartbeat)	☐	☐	High Cholesterol	☐	☐
Autoimmune disorder, Specify(_____)	☐	☐	HIV/AIDS	☐	☐
Cancer, Specify (_____)	☐	☐	Hyperthyroidism	☐	☐
COPD	☐	☐	Hypothyroidism	☐	☐
Coronary Artery Disease	☐	☐	Jaundice	☐	☐
Crohn's/Ulcerative Colitis	☐	☐	Keloids	☐	☐
Depression	☐	☐	Kidney Disease	☐	☐
Diabetes	☐	☐	Seizure/Epilepsy	☐	☐
End Stage Renal Disease	☐	☐	Stroke	☐	☐
GERD (Acid Reflux)	☐	☐	Tuberculosis	☐	☐
Peptic Ulcer	☐	☐	Organ Transplant (_____)	☐	☐

Other: _____

Past Surgical History

Please list all surgeries

1. _____ **5.** _____ **9.** _____ **13.** _____

2. _____ **6.** _____ **10.** _____ **14.** _____

3. _____ **7.** _____ **11.** _____ **15.** _____

4. _____ **8.** _____ **12.** _____ **16.** _____

Skin Disease History

Have you ever had:	YES	NO		YES	NO
Acne / Rosacea	☐	☐	Squamous Cell Skin Cancer	☐	☐
Actinic Keratoses	☐	☐	Herpes Simplex (Cold Sores)	☐	☐
Basal Cell Skin Cancer	☐	☐	Herpes Zoster (Shingles)	☐	☐
Eczema	☐	☐	Do you wear Sunscreen?	☐	☐
Flaking or Itchy Scalp	☐	☐	Do you use a tanning bed?	☐	☐
Hay Fever	☐	☐	Do you have a family history		
Melanoma	☐	☐	→ of Melanoma?	☐	☐
Precancerous Moles	☐	☐	If Yes, what relative?		
			_____		
Psoriasis	☐	☐			

Medications

Please list all medications, vitamins & herbs you are currently taking, **INCLUDING ASPIRIN**.

Name Strength/Dosage Taken/How Often

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Do you have any drug allergies? Yes No If yes, please list:_____

Please list any food, seasonal and contact allergies:_____

Social History

Tobacco Products: [ ] Never [ ] Current - Every Day [ ] Current-Some Days [ ] Former
(This Question is a requirement of the Federal Government.)

Professional Occupation:_____
Workplace:_____

Family Medical History – 1ST DEGREE RELATIVES ONLY (PARENTS / SIBLINGS/CHILDREN)

Do you have a family history of	YES	NO		YES	NO
Asthma	☐	☐	Hay fever	☐	☐
Atopic Dermatitis/Eczema	☐	☐	Melanoma	☐	☐
Blistering Disorder	☐	☐	Non-Melanoma Skin Cancer	☐	☐
Cancer, Specify (_____)	☐	☐	Psoriasis	☐	☐

Review of Systems: Are you currently experiencing any of the following? Check YES to those that apply.

Do you currently have:	YES	NO		YES	NO
Problems with bleeding	☐	☐	Fever or Chills	☐	☐
Problems with healing	☐	☐	Night Sweats	☐	☐
Problems with scarring	☐	☐	Unintentional weight loss	☐	☐
Rash	☐	☐	Joint Aches	☐	☐
Immunosuppression	☐	☐	Muscle Weakness	☐	☐
Hay Fever	☐	☐	Incontinence (Women 65 +)	☐	☐

!!! MEDICAL ALERTS !!!

	YES	NO		YES	NO
Allergy to Adhesive	☐	☐	MRSA	☐	☐
Allergy to Lidocaine	☐	☐	Pacemaker/Defibrillator	☐	☐
Allergy to topical antibiotic ointments	☐	☐	Antibiotics prior to surgery/dental procedures	☐	☐
Artificial Heart Valve	☐	☐	Pregnant or planning pregnancy (Circle one)	☐	☐
Artificial joints (within last 2 years)	☐	☐	Currently Breastfeeding	☐	☐
Blood Thinners (aspirin, Plavix, Coumadin, Pradaxa, Xarelto, Eliquis, Brilinta, Ticlid, generic)				☐	☐

1) **Do you have an Advance Directive?** (Healthcare Power of Attorney)
*YES*____ *NO*____