PATIENT INFORMATION

Appointment Date:

MRN #:

Patient Name:		**Nickname:**	
SSN:	**DOB:**	**Marital Status:**	**Gender:**

Primary Address: (for billing and other correspondence) ,
Secondary Address:

City: **State:** **Zip:**

Race: White/Caucasian American Indian Asian Black/African American Other______________
Language: English Other______________
Ethnicity: Hispanic/Latino Not Hispanic/Latino

WHEN CENTER FOR DERMATOLOGY AND PLASTIC SURGERY HAS TO CALL:
PLEASE NOTE: ALL numbers listed below are subject to phone or text confirmation for upcoming appointments and post-appointment surveys

What number do you want called **1st:** Home Cell Work Other______________________

What number do you want called **2nd:** Home Cell Work Other______________________

PLEASE NOTE: The numbers listed above are also subject to messages from our office

Primary Care Physician (PCP):
(Please list physicians first and last name- NOT facility) **Phone Number:**

Referring Physician (If any):
(Please list physicians first and last name- NOT facility) **Phone Number:**

What email address do you want to use for appointment confirmations, post-appointment surveys, newsletters, and your online patient portal:

How did you hear about our office:
Arcadia News Church Bulletin Internet/Search Engine Magazine___________________
Insurance Company News Segment Patient Referral ___________________ Physician Referral Real Self Sign
Social Media Website Word of Mouth Other____

May we discuss scheduling, billing, and/or your medical condition with any member(s) of your household:

If "Yes", whom (LIST ALL) **Relationship:**

Emergency Contact:
(If different from above) **Phone:** **Relationship:**

Parent/Responsible Party:
(If the patient is a minor) **DOB:** **Relationship:**

Responsible Party Address:
(If different from patient) **SSN:**

Primary Insurance Name: **Policy #:** **Group #:**
Subscriber/Policy Holder: **DOB:** **SSN:**

Secondary Insurance Name: **Policy #:** **Group #:**
Subscriber/Policy Holder: **DOB:** **SSN:**

BY SIGNING THIS FORM I CONSENT TO BE TREATED AT CENTER FOR DERMATOLOGY & PLASTIC SURGERY

PAYMENT POLICY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay for any non-covered services and co-payments. In the event that your account becomes delinquent, a $25 late fee may be added to your account. Returned checks will incur a $25 additional fee. If your account becomes delinquent and we are unable to collect, your account will be sent to collections, and you will be responsible for your balance plus the collection fee of up to 50% of your balance.

CANCELLATION AND NO-SHOW POLICY

We ask that you give at least 24 hours notice in the event that you must cancel your appointment. All appointments cancelled within 24 hours will be considered "No Show." "No Show" will result in a $50 fee ($75 fee for cosmetic/surgeries), per instance, added to your account. We don't bill for preventive care. It is the responsibility of the patient(s) to obtain referrals.

AUTHORIZATION TO RELEASE INFORMATION AND RECEI E PAYMENT

I authorize the release of medical information to my primary or referring physician, to consultants, if needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician.

By signing below, I acknowledge that I have read, understand, and agree to the Notice of Privacy Practices and Office Policies:

Patient or Parent/Guardian Signature: ate:

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Due to new requirements from the United States Department of Health and Human Resources, it is required that all patients complete the following questionnaire. This is a federal requirement and must be completed at each visit in order for you to be seen. Please refer to the Quality Measures handout if you have concerns regarding the reasoning behind why you are being asked these questions and directions on where to direct any complaints/concerns you may have.

PATIENT NAME: DOB: ________ TODAY'S DATE:

ADVANCED CARE PLAN:

Do you have one of the following?

☐ Power of Attorney (Surrogate Decision Maker) ☐ Living Will (Advance Care Plan) ☐ None

Name/Relationship: ____________________________________

TOBACCO USE:

Please choose the option that best describes your tobacco use:

☐ Never ☐ Current smoker ☐ Previous smoker

For current tobacco users, select the option that best describes use:
☐ 1-3 cigarettes per day ☐ Up to 1 pack per day ☐ 1-2 packs per day ☐ 2 or more packs a day

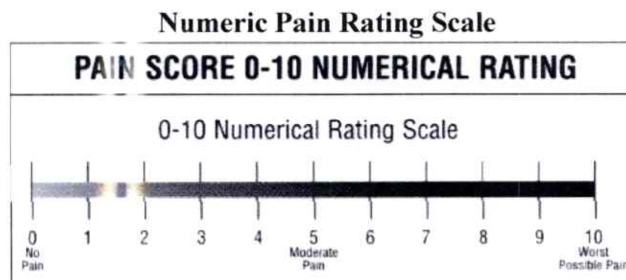
VACCINATIONS: Have you received the following vaccinations?

Flu vaccine in 2019 during Flu season: ☐ YES ☐ NO
(January – March, October – December)
Shingles - Year: ☐ YES ☐ NO
HPV - Year: ☐ YES ☐ NO
Pneumonia vaccine Year: ☐ YES ☐ NO

PAIN:

Aside from general aches (i.e. muscle, head, tooth), are you currently experiencing any pain related to your dermatology visit today?
☐ YES ☐ NO
If yes, please circle the number that corresponds with the amount of pain you are currently in:

Numeric Pain Rating Scale



By signing below, I attest that the above is true to the best of my knowledge

____

Signature of Patient or Patient's Legal Guardian

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MEDICAL HISTORY

NAME ______________________ DOB __________ AGE __________ DATE __________

HEIGHT __________ WEIGHT __________ OCCUPATION ______________________

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow
- ☐ Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Herpes/Cold Sores
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ NONE
- ☐ Other ______________________

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Facial Plastic Surgery
- ☐ Liposuction
- ☐ Tummy Tuck
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD -Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer Prostate Removed:
- ☐ Prostate Cancer Prostate Biopsy
- ☐ TURP (Prostate Removal)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ NONE
- ☐ Other ______________________

SKIN DISEASE HISTORY: (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/ Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other ______________________

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? __________

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, in who? __________

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MEDICATIONS (list all) ______________________________

ALLERGIES (list all) ______________________________

CURRENT SKIN CARE REGIMEN ______________________________

SOCIAL HISTORY: (Please check all that apply)

Cigarette Smoking:
- ❑ Currently Smokes
- ❑ Former Smoker
- ❑ Never smoked
- ❑ Use other tobacco products

Alcohol Use:
- ❑ EtOH - None
- ❑ EtOH - <1 drink per day
- ❑ EtOH - 1-2 drinks per day
- ❑ EtOH - >3 drinks per day

Married ❑ Yes ❑ No
Children ❑ Yes ❑ No

SERIOUS FAMILY ILLNESSES ______________________________

Preferred language: ____________ Race: ____________ Ethnicity: ____________
Preferred Pharmacy: ____________ Phone# ____________ City or Zip Code: ____________

REVIEW OF SYSTEMS (Please check any symptoms you are currently experiencing)

- ❑ NONE
- ❑ Immunosuppression
- ❑ Hay Fever
- ❑ Chest Pain
- ❑ Fever or Chills
- ❑ Night Sweats
- ❑ Unintentional Weight Loss
- ❑ Thyroid Problems
- ❑ Sore Throat
- ❑ Blurry Vision
- ❑ Abdominal Pain
- ❑ Bloody Stool
- ❑ Bloody Urine
- ❑ Problems with Bleeding
- ❑ Other Skin Complaints
- ❑ Problems with Healing
- ❑ Problems with Scarring
- ❑ Rash
- ❑ Joint aches
- ❑ Muscle Weakness
- ❑ Neck Stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ HIV Positive
- ❑ Allergy to Epinephrine
- ❑ Allergy to Lidocaine
- ❑ Allergy to Topical Antibiotics
- ❑ Allergy to Adhesive
- ❑ Allergy to Latex
- ❑ Artificial Heart Valve
- ❑ Artificial Joints w/in last 2yrs
- ❑ Blood thinners
- ❑ Defibrillator
- ❑ MRSA
- ❑ Pacemaker
- ❑ Requires Premedication prior to Procedures
- ❑ Rapid Heart Beat with Epinephrine
- ❑ Pregnant or trying
- ❑ Anxiety
- ❑ Depression
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Breastfeeding
- ❑ Herpes/Cold Sores
- ❑ Other ______________________________

How did you hear about us? ______________________________
Can we thank them? ❑ Yes ❑ No