Today's Date: ___________

PATIENT INFORMATION

Patient's Last Name: ___________________________ First: __________________________ M.I. __________

Mailing Address: _______________________________ City: _____________ State: _______ Zip: _________

Home Phone: (______)______________ Cell: (______)_______________ Work: (______)_______________

Date of Birth: ______ /______ /______ Age: _________ Sex: _________ SSN: _________________________

Driver's License #: __________________________________ Marital Status: ___________________________

Email Address of Patient or Responsible Party: ____

RESPONSIBLE PARTY (If Different from Patient)

Last Name: ________________________________ First: ______________________________ M.I. _________

Mailing Address: _______________________________ City: _____________ State: _______ Zip: _________

Home Phone: (______)______________ Cell: (______)_______________ Work: (______)_______________

Date of Birth: ______ /______ /______ Sex: _________ Driver's License #: ___________________________

POLICY HOLDER INFORMATION (If Different from Patient)

Policy Holder Name: ______________________________________ Date of Birth: ______ /______ /______

SSN: _____________________ Employer: ___________________________ Phone: (______)_______________

Relationship to the Patient: ____

How Did You Hear About Us? (Please Check One)

Family _______ Friend _______ Doctor _______ Insurance _______ Facebook _______ Website _______

Other: ____

Referring Physician: ____ Phone: (______)______________

Do We Have Permission to: (Please Circle One)

Leave messages on your home/cell answering machine? **Y** or **N**

Leave messages at your place of employment? **Y** or **N**

Leave messages regarding biopsy or lab results? **Y** or **N**

Discuss your medical condition with any member(s) of your household? **Y** or **N**

If Yes, Whom? ____ Relationship: __________________________

In case of emergency, who should be notified? ____

Relationship: ____ Phone: (______)______________

I hereby consent to treatment by Dermatology & Skin Cancer Surgery Center for the care of the patient indicated on this form. I authorize the release of medical information to my primary care, referring physician or other specialist and as necessary to process insurance claims or assist in the patient's treatment. I also authorize payment of medical benefits to the provider.

Signature of Patient OR Responsible Party ____

(PLEASE COMPLETE BACKSIDE)

FINANCIAL POLICY

Our policy is to collect payment at the time of service. If you are a member of one of our contracting insurance companies, we require you to present the insurance card at the time of service. If you are unable to provide this, we will collect payment in full. If we do not participate with your current insurance plan or you do not have health coverage we will collect payment in full at time of service. Should your payment result in NSF (non-sufficient funds) we will apply an additional $25.00 to the balance for fees applied by the bank. At any time if your balance is referred to collections for non-payment we will apply an additional $20.00 to your current balance. You will also be responsible for any fees charged by the agency for cost of collections.

Please remember your insurance policy is a contract between you and the insurance company. You are responsible for all charges incurred on your account. It is your responsibility to make sure all of your information on your account is current and accurate. It is your responsibility to know what your contract covers or pays regarding your co-pay/deductible/co-insurance amount and any restrictions your insurance company might have, including, but not limited to, pre-existing exclusions, cosmetic exclusions and prior-authorizations. Cosmetic procedures are not a covered service with your insurance company, making you solely responsible for these charges.

If your health plan requires a referral or authorization for specialty services, it is your responsibility to make sure your primary care physician sends this to us before your scheduled appointment. If a referral is required and has not been received in our office, you may either (1) pay for your services in full at the time of service or (2) change your appointment to a later date.

I have read and agree to the terms of Dermatology & Skin Cancer Surgery Center's financial policy.

____ ________________

Signature of Patient or Legal Guardian (if under 18) **Date**

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 2013 (HIPAA)

Please sign below acknowledging that you have been given the opportunity to review our notice of privacy practices. Written copies of the current HIPAA policy are available to review upon your request. **Signing only confirms you have been given the opportunity to review HIPAA at your discretion.**

____ ________________

Signature of Patient or Legal Guardian (if under 18) **Date**

(PLEASE COMPLETE BACKSIDE)

DERMATOLOGY & SKIN CANCER SURGERY CENTER

CONSENT FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OR MINOR SURGERY AND/OR PROCEDURES

1. I do hereby authorize the use and the administration of such drugs, anesthetics and other treatments, including the performance of skin biopsy, the use of cryosurgery with liquid nitrogen and the injection of intralesional cortisone, should any of these be deemed advisable, desirable or necessary for diagnostic, therapeutic or investigational purposes by any appropriately trained and/or licensed health care professional on the medical staff of Dermatology & Skin Cancer Surgery Center, for myself or my dependent.
2. I further consent to the examination for diagnostic or investigational purposes and disposal by authorities of the above named medical facility or its designates herein, of any tissue or parts which may have been removed.
3. I understand that the skin biopsy involves removal of a piece of tissue and that such removal may result in a permanent scar or discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.
4. I understand that all specimens removed are sent for analysis by a dermatopathologist and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of these charges.
5. I understand that the destruction of precancerous lesions, also known as actinic keratosis or solar keratosis, by liquid nitrogen may be deemed necessary by a member of the medical staff of Dermatology & Skin Cancer Surgery Center to prevent the risk of these lesions evolving into Squamous Cell Carcinoma.
6. I understand that the destruction of warts or molluscum by liquid nitrogen may be advised by a member of the medical staff of Dermatology & Skin Cancer Surgery Center, but these types of lesions are not cancerous and do not necessarily need to be treated. I am aware that these lesions may require more than a single treatment.
7. I understand that the injection of intralesional cortisone for the treatment of scars, cysts, acne and inflammatory conditions like psoriasis, atopic dermatitis and alopecia areata may be deemed necessary, advisable or desirable by a member of the medical staff of Dermatology & Skin Cancer Surgery Center.
8. I understand that any of the above procedures may have some unwanted side effects, which include, but are not limited to, permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).
9. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I acknowledge that I have read and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize my provider(s) to perform the above discussed procedures as deemed necessary in my treatment plan.

Signature of Patient ____ Date: ______________

If patient is Under the Age of 18 or Unable to Authorize Consent:

Signature of Parent or Legal Guardian ____ Date: ______________

HISTORY AND INTAKE FORM

Patient Name: ______________________ Patient DOB: ______________

Today's Date: ______________

Reason for Today's Visit: ______________________

Past Medical History: (Please circle all that apply)

Anxiety	Depression	High Blood Pressure	Lymphoma
Arthritis/Osteoarthritis	Diabetes	HIV/AIDS	Multiple Sclerosis
Asthma	End Stage Renal Disease	High Cholesterol	Rheumatoid Arthritis
Atrial Fibrillation	Fibromyalgia	Hyperthyroid	Seizures
Bone Marrow Transplant	GERD	Hypothyroid	Stroke
COPD	Hearing Loss	Leukemia	**NONE**
Coronary Artery Disease	Hepatitis	Lupus	

Cancer: ______________________

Other: ______________________

Past Surgical History: (Please circle all that apply)

Appendix Removed	Coronary Artery Bypass	Ovaries Removed
Bladder Removed	Mechanical Valve Replacement	Prostate Removed
Breast Biopsy (Right/Left)	Biological Valve Replacement	Spleen Removed
Lumpectomy (Right/Left)	Hip Replacement (Right/Left)	Testicles Removed
Mastectomy (Right/Left)	Knee Replacement (Right/Left)	Thyroid Removed
Breast Implants	Kidney Biopsy	Partial Hysterectomy
Colectomy	Kidney Stone Removal	Full Hysterectomy
Gallbladder Removed	Kidney Removed (Right/Left)	**NONE**

Organ Transplant: ______________________

Other: ______________________

Skin Disease History: (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Psoriasis
Asthma	Flaking or Itchy Scalp	Rosacea
Atypical Moles	Hay Fever	Shingles
Basal Cell Skin Cancer	Seasonal Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	**NONE**

Other: ______________________

Do you wear sunscreen? **YES** **NO** If yes, what SPF? __________

Do you or have you ever tanned in a tanning salon? **YES** **NO** When? __________

Do you have family history of Melanoma? **YES** **NO**

If yes, which relative(s)? ______________________

Do you have family history of Non-Melanoma Skin Cancer? **YES** **NO**

If yes, which 1st degree relative(s)? ______________________

(PLEASE COMPLETE BACKSIDE)

Medications & Dosages: (Please list all current medications and dosages)

____

____

____

Drug Allergies: (Please list all medication allergies)

____

____

____

Alerts: (Please circle all that apply)

Allergy to Adhesive	Artificial Heart Value	Pacemaker
Allergy to Lidocaine	Blood Thinners	Defibrillator
Allergy to Topical Antibiotics	MRSA	Other Electronic Implanted Device

Have you had a joint replacement within last 2 years? **YES** **NO**
Does epinephrine give you rapid heartbeat? **YES** **NO**
Do you require antibiotics prior to a surgical procedure? **YES** **NO**
Do you have a history of fainting? **YES** **NO**
Are you pregnant or currently trying to get pregnant? **YES** **NO**

Vaccine History: (Please circle all that apply)
Have you had the flu vaccine? **YES** **NO** When? ____________
Have you had the pneumonia vaccine? (65 or older) **YES** **NO**

Preferred Pharmacy Name: ______________________________

Pharmacy Phone #: ____________________ City or Zip Code: ____________________

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently Smoke Cigarettes	3 or more drinks per day
Smoke Electronic Cigarettes	1-2 drinks per day
Have Smoked in the past	Less than 1 drink per day
Never Smoked	**NONE**

Occupation: ____________________ Hobbies: ____________________

Preferred Language: ____________________ Race: ____________________

Ethnic Group: ____________________

Details/Comments: ____

____

____