Today's Date:___/____/_______ Name:_________________________________________ Birth Date:_____/______/_______

**Medical History Questionnaire**

The reason for today's visit: ________________________________________________________________

Present for how long?______________________

**Personal Dermatological History** ***Please check if you have a history of:**

☐Skin Cancer

Which Type?

☐Melanoma- When? _________________ Body Location?___________________

☐Basal Cell Cancer- When? ____________ Body Location? __________________

☐Squamous Cell Cancer- When? ___________ Body Location?_______________

☐Actinic Keratosis (Precancerous Skin Growth)

☐Eczema ☐Psoriasis ☐Lupus ☐Scarring Acne

☐Other Dermatologic Condition(s)________________________

☐**NONE**

**Medical History** ***Please check if you have a history of:**

☐Allergies/Sinusitis
☐Artificial Heart Valve
☐Asthma
☐Bleeding Disorder
☐Cancer (Other than skin cancer)
Which type?_____________
☐Cataracts
☐Cold Sores (Herpetic Infection)
☐Congestive Heart Failure
☐Depression
☐Diabetes
☐Pacemaker
☐Diabetes Mellitus
☐Emphysema/COPD
☐Epilepsy
☐GERD/(Reflux Disease)
☐Glaucoma
☐Heart Arrhythmia
☐Heart Disease
☐Hepatitis
☐High Cholesterol
☐HIV or Aids
☐Hypertension
☐Defibrillator
☐Irritable Bowel Syndrome
☐Mitral Valve Prolapse
☐Organ Transplant
☐Osteoarthritis
☐Osteoporosis
☐Rheumatic Fever
☐Rheumatoid Arthritis
☐Stomach Ulcer
☐Thyroid Disease
☐Tuberculosis
☐Other____________
☐**NONE**

**For Women:** Are you currently pregnant OR actively trying to get pregnant OR breastfeeding? ☐Yes ☐No

**Social History** Do you wear sunscreen regularly? ☐Yes ☐No Use tanning beds? ☐ Yes ☐No

Do you smoke? ☐Yes ☐ No Drink alcohol? ☐Yes ☐ No Use drugs? ☐Yes ☐No

**Family History** ***Do any family members suffer from the following?** ☐ IF NONE

| **Condition** | **Family Member (Relationship)** |
|---|---|
| Skin Cancer (Other than Melanoma) | |
| Melanoma | |
| Asthma/Eczema/Seasonal Allergies | |
| Psoriasis | |

## MEDICATION AND ALLERGY LIST

| MEDICATION/FOOD ALLERGIES | REACTION |
|---|---|
| | |
| | |
| | |

Any allergy to: Adhesive ☐Yes ☐No Lidocaine ☐Yes ☐No
Epinephrine ☐Yes ☐No Latex ☐Yes ☐No
Antibiotic Ointment ☐Yes ☐No

## CURRENT MEDICATIONS

| MEDICATION NAME | MEDICATION STRENGTH | DOSE | DOSE FORM | MEDICATION FREQUENCY |
|---|---|---|---|---|
| | | | | |
| | | | | |
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| | | | | |

Please Initial for No Known Drug Allergies: _________
Please Initial for No Current Medications: _________

I hereby certify that the above information is true and accurate, to the best of my knowledge.

______________________________ ________________________________ ______________
Patient/ Guardian Signature Patient/ Guardian Print Name Date

Relationship if other than patient:_____________________________________________

Thank you for choosing Complete Dermatology as your health care provider. It is our goal to meet patient needs and address patient concerns effectively. Areas of primary concern for all patients are financial policies of the practice, especially those pertaining to insurance billing and patient payment requirements. As in all aspects of healthcare today, the greater role the patient assumes in the healthcare process, the higher the degree of satisfaction achieved. For that reason, we expect our patients to take an active role in their healthcare management, including the area of finances. In an effort to keep patients informed about such policies, we ask that all patients read and sign a copy of our financial policy prior to receiving treatment.

**PAYMENTS** are expected at the time services are rendered. This includes all deductibles, co-insurance, co-payments and any non-covered services, such as cosmetic procedures. Patients who have an insurance carrier with whom the practice has a valid contract will be responsible for all fees as outlined in the patients' contract agreement.

**INSURANCE** is filed for all primary and secondary carriers for whom the practice has a valid contract. The patient is responsible for filing claims for carriers for whom the practice does not have a valid contract. This includes all carriers who are secondary to Medicare that are not Medigap crossover carriers. There can be significant variance on services covered, deductibles, co-pay requirements, network requirements, pre-authorization for services, and other requirements of the policy. It is the insured's responsibility to verify that the services requested and the physicians are covered by the terms of your insurance plan. If any services are denied as out of network, not covered by the terms of the policy, policy not in force, not medically necessary, or have a deductible/co-pay issue, the patient or responsible party will be billed.

I authorize treatment of the person named and authorize information given to the insurance companies.

I agree to pay all charges on day of service unless credit arrangements are agreed upon in writing with the practice. Any patient to walk out of the office without making or arranging payment will be assessed a $40.00 walk-out fee. If any services are denied by insurance, the patient or responsible party will be billed. Outstanding balances of 90 days are subject to collection fees.

Returned checks will result in a $25.00 service charge. Payment of the check amount plus service charge is 10 days upon notification. Failure to pay in full within 10 days will result in collection through the appropriate means.

All appointments cancelled less than 1 business day or no-shows, will be assessed a cancellation/no-show fee of $25.00

________________________________________ ______________________________
Signature of Patient or Authorized Representative Date

Relationship if other than patient:________________________________________________

I acknowledge that Complete Dermatology has made the Notice of Privacy Practices available to me. I authorize release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorized payment of medical benefits to the physicians.

________________________________________ ______________________________

Signature of Patient or Authorized Representative Date

Relationship if other than patient:______________________________________________

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that communication or PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving lab or procedure results with a spouse.

I wish to be contacted in the following manner.

Phone number:__________________________________

☐Leave a message with a callback number
☐Leave medical information with my spouse
☐Do not leave a message
☐Leave a message with detailed information
☐Discuss medical information with:___________________________________________

OR

☐Text message (When Available)
☐Email (When Available)

In the future, I would like to have my appointments confirmed via:

☐Cell Phone
☐Text Message
☐Email

**Unless a fax machine is in a secure area, Protected Health Information (PHI) can not be faxed.**

This Consent will remain in effect unless otherwise revoked in writing.

________________________________________ ______________________________

Signature of Patient or Authorized Representative Date

Relationship if other than patient:__________________________________________