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

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

Vaccinations: ☐Flu vaccine this year ☐Flu vaccine last year ☐Pneumonia vaccine this year ☐Pneumonia vaccine last year ☐HPV Vaccine ☐Td/Tdap ☐ Meningococcal vaccine

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

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: Name :_____

☐Do not leave a message

☐Leave a message with detailed information

Please list any other individuals that are authorized to discuss information regarding medical/billing and/or scheduling:

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

☐Cell Phone

☐Text Message

☐Email

Unless a fax machine is 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:_____