CONTEMPORARY DERMATOLOGY

MEDICAL | SURGICAL | AESTHETIC

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Birth Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Other

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ SSN: _____-_____-_____

Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____ Preferred Contact: □ Home Phone □ Cell Phone

Email Address: _____

Preferred Pharmacy: _____ City: _____ Telephone: (_____) _____-_____

Primary Care Physician: _____ City: _____ Telephone: (_____) _____-_____

Referring Physician: _____ City: _____ Telephone: (_____) _____-_____

New Patients: How did you hear about Contemporary Dermatology? _____

Emergency Contact:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____ Primary Contact: (_____) _____-_____

Primary Insurance Plan: _____ Member I.D. _____

Subscriber Name: _____ Date of Birth: _____/_____/_____ Check if same as patient: □

Subscriber's Relationship to Patient: _____

Secondary Insurance Plan: _____ Member I.D. _____

Subscriber Name: _____ Date of Birth: _____/_____/_____ Check if same as patient: □

Subscriber's Relationship to Patient: _____

PATIENT RELEASE: MUST BE SIGNED BY PATIENT OR, IF PATIENT IS A MINOR, THE LEGAL GUARDIAN.

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies, including Medicare, for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I understand I am responsible for co-insurances, co-payments, and deductibles. If I am not insured, or if Contemporary Dermatology does not participate in my plan, I am responsible for payment in full at the time of service.

Patient or Legal Guardian Signature: _____ Date: _____/_____/_____

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Patient Name: _____

Current and Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Gastroesophageal Reflux Disease
- ☐ Hearing Loss
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Kidney Disease
- ☐ Malignant Tumor
  If yes, please specify: _____
- ☐ Radiation Therapy Treatment
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other: _____

Surgical History

- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Hysterectomy
- ☐ Joint Replacement
  If yes, please specify: _____
- ☐ Lumpectomy L / R
- ☐ Mastectomy L / R
- ☐ Mechanical Heart Valve Replacement
- ☐ MOHS Surgery
- ☐ Organ Transplantation
  If yes, please specify: _____
- ☐ Pacemaker
- ☐ Prostatectomy
- ☐ Other: _____

Social History

Tobacco Use
□ Current Smoker □ Former Smoker □ None

Alcohol Use
Do you consume alcohol? □ Yes □ No

If yes, how often? _____

Female Patients

Are you pregnant? □ Yes □ No

Are you nursing? □ Yes □ No

Are you trying to conceive? □ Yes □ No

Skin Disease History

- ☐ Atypical Moles
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma of Skin
- ☐ Eczema
- ☐ Hay Fever
- ☐ Malignant Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Sunburn of Second Degree
- ☐ Systemic Lupus Erythematosus
- ☐ Xeroderma
- ☐ Other: _____

Do you have a family history of melanoma? □ Yes □ No

If yes, please specify: _____

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

Do you wear sunscreen? □ Yes □ No

If yes, what SPF? _____

Medication and Allergies

Medication(s): _____

_____

_____

Do you have any allergies to medication? □ Yes □ No

If yes, please specify: _____

_____

Have you had an allergic reaction to the following?

□ Latex □ Lidocaine □ Epinephrine □ Iodine □ Adhesives

Other Allergies: _____

_____

Immunization History

Have you received the Pneumococcal vaccine? □ Yes □ No

Have you received the Influenza vaccine? □ Yes □ No

Patients 65+

Do you have a Living Will? □ Yes □ No

Do you have a Health Care Proxy? □ Yes □ No

If yes, please specify: _____

Do you have a Do Not Resuscitate Order? □ Yes □ No

Do you have a Do Not Intubate Order? □ Yes □ No

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Our goal is to provide you and your loved ones with the best possible care in a warm, supportive environment. Below are policies that manage those expectations and assure understanding to develop a long-lasting relationship. We remain available for any questions or concerns you may have.

Appointment Cancellations and No-Shows

- I understand late cancellation(s) or missing an appointment keeps other patients from being seen. I understand arriving late means I have forfeited my appointment time and other patients arriving on time will be served while I am worked back into the schedule whenever possible.
- I understand Contemporary Dermatology will do its best to accommodate me should I arrive late for an appointment. I also understand that there may be times when these accommodations are not available, and I will be asked to reschedule.

Referrals

- **I understand it is my responsibility to be aware of my health insurance policy requirements and if an authorization is needed to see a specialist. It is my responsibility to obtain this authorization prior to my appointment.**
- I understand if this authorization is not done prior to my initial visit, my insurance company may not cover the expense of the visit nor will they back date an authorization. Should I fail to have a valid authorization for my appointment, I will either need to reschedule my appointment or pay in full at the time of service. If I decide to see the provider without an authorization, my insurance company will not reimburse me.

Minor Patients

- **I understand a legal guardian MUST accompany my child under the age of 18 to their initial appointment and to subsequent appointments where an additional consent will be required.**
- I understand minors without a legal guardian present at their initial visit will be rescheduled. Notes from legal guardians with permission to treat while with grandparents, babysitters, older siblings, etc. are not acceptable.
- I understand that unless documents are provided showing otherwise, both parents are assumed to make appointments and treatment decisions for their child.
- I understand payment such as co-payments, deductibles, etc. are due at the time of service regardless of which parent is responsible for medical coverage. We will collect payment due from the parent who brings the child to the appointment. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- Payments remain due at time of service, even at times when the parent or legal guardian is not present for the appointment and can be handled with the Credit Card on File or arrangements made prior to the visit.

Insurance

- I will confirm my insurance is active and will provide a valid insurance card or I.D. at the time of my appointment or will be responsible for all charges. If I am unable to produce this information, I will either need to reschedule my appointment or pay in full at the time of service.
- I understand any existing balances are due in full within 30 days of the statement date. If the balance is not paid in this time, my account may be sent to collections.

Patient or Legal Guardian Signature: _____ Date: _____/_____/_____

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NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential to promote privacy and trust between you and your health care provider. Staff members at Contemporary Dermatology are prohibited from discussing protected health information, including appointments, test results, or treatment plans, with anyone other than the patient.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information.

We are only allowed to use and disclose medical information in the manner that is described in the Notice.

The HIPAA Privacy Rule sets rules for health care providers and health plans about who can look at and receive your health information, including those closest to you. If applicable, please indicate the individual(s) your health care provider has permission to disclose your health information to.

Individual and Relationship to Patient	Telephone

I acknowledge and understand the above HIPAA policies and understand I may request a copy of the Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

Patient or Legal Guardian Signature: _____ Date: _____/_____/_____