COMPLETE DERMATOLOGY

PATIENT INFORMATION

Date of Birth _____ **First Name** _____ **MI** _____ **Last Name** _____

Home Address _____ **City** _____ **State** _____ **Zip Code** _____

Email Address _____ **Marital Status** _____ **MALE/FEMALE (Circle One)**

Home Number: _____ **Cell Number:** _____

Referring Physician's Name: _____ **Referring Physician's Phone #:** _____

***Please note that by signing below you acknowledge we will release medical records to your referring physician.**

INSURANCE INFORMATION (Please fill this section out!)

Primary Insurance : BCBS/AETNA/UNITED HEALTHCARE/CIGNA/HUMANA/MEDICARE

If not listed above write the name of your insurance: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____ Relationship to Patient: _____

Secondary Insurance : BCBS/AETNA/UNITED HEALTHCARE/CIGNA/HUMANA/MEDICARE

If not listed above write the name of your insurance: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____ Relationship to Patient: _____

OTHER INFORMATION

Emergency Contact Name & Phone Number: _____

Full-time Student: Yes/No Is the Patient a Minor? Yes/No

How did you hear about us? Physician/Friend/Family/Google

Permission to treat minor without parent in the office? YES/NO

Parent or Legal Guardian Name& Phone Number: _____

SIGNATURE

Patient or Parent/Guardian Signature _____ **Date** _____

Thank you for choosing Complete Dermatology. We provide medical and cosmetic dermatology services to patients of all ages. We strive to return all calls on the same business day. Please visit our website at www.complete-derm.com to schedule appointments, obtain results, and pay your bill. We are glad you are here.

NOTICE OF INFORMATION—PLEASE READ THIS CAREFULLY!

WEBSITE: You can use our website at https://complete-derm.com/ to make appointments, pay your bill, and get your benign pathology results. Just go to the website and click on the PATIENT section at the top of the page!

PATHOLOGY: When biopsies or excisions are performed in the office, it takes up to 2 weeks to receive the results from the pathology lab. **WE WILL USE THE PATIENT PORTAL TO NOTIFY YOU IF THE RESULTS ARE NORMAL OR BENIGN. If your pathology or lab results are abnormal, we will call you.** As notified in our Financial Policy, outside pathology charges may be incurred when biopsies or other excisions are performed. You may get a bill from a dermatopathologist. This bill is your responsibility. If you do get a bill for the pathology and have questions, please call your insurance company. By signing this form you understand the policy and give us permission to call and leave a message and/or email you with results for laboratory and pathology.

REMINDER CALLS/RECALLS: Our system is set up to text and email you reminders of your upcoming appointments or when it is time to schedule an appointment. IF you do not have a cell phone or email, then you will receive a phone call. It is your responsibility to notify the office at least 24 hours if you need to cancel an appointment. See the Financial Policy for more information on this.

RELEASE OF INFORMATION: I give permission to disclose/discuss all of my medical information with the following person(s):

_____

Name DOB Relationship

_____

Name DOB Relationship

OPTIONS FOR PAYMENT: We accept cash, check, and most credit cards. You can determine which method of payment you would like us to keep on file.

CREDIT CARD ON FILE: All patients that have insurance with coinsurance or deductibles may be required to keep a credit card on file. This innovative system prevents errors in determining your payment responsibility. Your card information is stored securely and we will NEVER charge your card more than what you owe or without your knowledge. We will bill your insurance company first and allow them to calculate your responsibility. At that time we will send you an email to inform you of the charge, and will debit your card on file unless we hear from you. If you are unable or unwilling to leave a credit card on file, we will collect your estimated charges in full at the time of your visit and send you a bill or refund for any amounts owed or due to you after insurance processes your claim. If your account becomes delinquent, a 25.00 service charge will be placed on the account and the account will be sent to a collection agency.

SIGNATURE: By signing below, you acknowledge you have read and understand these disclosures as well as the Financial Policy/Privacy Notice/Acceptance of Liability Waiver that was provided to you on your first visit. If you need to review the Policy, or if for any reason you need further explanation, please see the receptionist. This consent will remain in effect unless otherwise revoked in writing.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

PRINT PATIENT NAME HERE PATIENT'S DATE OF BIRTH

Medical Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

How did you find us? **Internet/ Family or Friend**(Name: _____)/ **Physician** (Name: _____)

The reason for today's visit: _____

How long has this issue or illness been present?_____

What have you tried to treat it? _____**Pharmacy Name &Number**_____

Check the following medical conditions that you currently have:

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Ds
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Failure
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:_____

Please List All Past Surgeries:

Year_____Surgery Performed_____ Year_____Surgery Performed_____

For FEMALES only: Are you breastfeeding or trying to get pregnant? _____

Have you had any of the following skin conditions? Check only those that apply to you.

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

If you have had Basal Cell, Squamous Cell or Melanoma, please indicate location of the body below.
_____

Do you wear Sunscreen? _____ If so, what SPF? _____ Do you use a tanning salon? _____

Family History
Do you have a family member with Melanoma? Yes/No If yes, which relative?_____

Current Medications: Please list the medication and the dosage and how many times per day you take it.

Medication Name	Strength	How many times per day
Medication Name	Strength	How many times per day
Medication Name	Strength	How many times per day
Medication Name	Strength	How many times per day

Do you have any allergies: Please list below

Allergy and type of reaction	Allergy and type of reaction
Allergy and type of reaction	Allergy and type of reaction

Other Information:

Do you smoke? ____ If yes, how many packs per day?_____ Total years smoking? _____

Do you use drugs? ____ If yes, have you used IV drugs? How long?_____

Do you drink Alcohol? _____ If yes, how many per day? _____

Please use this space to add additional information, surgeries, or medications:

_____

_____

Name:_____ **Today's Date:**_____

Do you have/had any of the following? Put a check mark in the box IF it applies to you and your health history.

RASH ☐
PROBLEMS WITH SCARRING ☐
PROBLEMS WITH HEALING ☐
HISTORY OF MELANOMA ☐
ARE YOU TAKING BLOOD THINNERS ☐
PROBLEMS WITH BLEEDING ☐
PACEMAKER OR DEFIBRILLATOR ☐
ALLERGY TO LATEX OR ADHESIVES ☐
ALLERGY TO LIDOCAINE ☐
ACHY JOINTS ☐
ALLERGY TO TOPICAL ANTIBIOTIC OINTMENTS ☐
ARTIFICIAL HEART VALVE ☐
ARTIFICIAL JOINTS WITHIN LAST 2 YEARS ☐
SHORTNESS OF BREATH ☐
PREMEDICATE PRIOR TO PROCEDURES ☐
IMMUNOSUPPRESSION ☐
HAY FEVER ☐
CHEST PAIN ☐
FEVER OR CHILLS ☐
NIGHT SWEATS ☐
UNINTENTIONAL WEIGHT LOSS ☐
THYROID PROBLEMS ☐
SORE THROAT ☐
BLURRY VISION ☐
ABDOMINAL PAIN ☐
MUSCLE WEAKNESS ☐
NECK STIFFNESS ☐
HEADACHES ☐
SEIZURES ☐
COUGH ☐
DEPRESSION ☐
NONE ☐