Welcome to our practice!

We appreciate the opportunity to provide you with your skin care needs!

Currently, our office is open: Monday – Thursday 8am to 5pm and Friday 8am to 12 pm

We see all patients on an appointment basis and ask that you call in advance so that we may reserve time for you. If you cannot keep an appointment, please notify us immediately, when possible. We ask that you give at least *24-hour* notice so that the time may be given to another patient.

Please bring updated medication list, and insurance information with you to each visit, so that we may keep your medical record up to date and provide you with optimal care.

At Advanced Dermatology and Skin Cancer Institute, we want to be a blessing for those we serve. To care for not only the skin, but to fully care all who walk through our door. To prevent illness when we are able, to cure whenever possible, and to provide care and support when no cure can be found. We pledge to be more than just a clinic. We try to treat each patient as if they were part of our own family.

Again, welcome to our clinic. If you have any questions, please feel free to ask anyone on our staff.

Please check any issues below that are currently affecting you:

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (thick scars or keloids)
- ☐ Rash
- ☐ Nonmelanoma skin cancer
- ☐ Melanoma skin cancer
- ☐ Immunosuppression
- ☐ Hay fever
- ☐ Chest Pain
- ☐ Fever or chills
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry version
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointment
- ☐ Artificial heart valves
- ☐ Artificial joints in the last 2 years
- ☐ Blood thinners (including aspirin)
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ MSRA (Staph infection)
- ☐ Premedication prior to procedures (Teeth cleaning)
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning pregnancy
- ☐ Vasovagal reaction (passing out)

Please give this form to your nurse

Medication List

Name: _____ Date of Birth: _____

Please list the medications and dosage

☐ **No change** ☐ **See List**

_____ _____

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Please give this form to your nurse

MIPS

Name: _____ Date: _____

***Primary Care Provider: _____**

*Were you ***referred*** for this visit? ☐ **YES** ☐ **NO** Referring provider? _____

*In the event of an emergency, **CHECK ALL** below that correspond to your health care planning at this time:

I want FULL CODE ☐ I want all resuscitation efforts: CPR, intubation, shocking with paddles, medications, etc.	☐ **I am ON HOSPICE**
I do NOT want INTUBATION ☐ I do NOT want a tube inserted for breathing.	☐ **I have a LIVING WILL**
I do NOT want RESUSCITATION ☐ I do *NOT* want resuscitation (CPR, shocking with paddles, medications, etc.)	☐ **I have a surrogate decision maker** Name of surrogate decision maker (Optional)

***Personal Tobacco Use:** ☐ **Ex-Smoker** ☐ **Never Smoked** ☐ **Current tobacco user**

Counseling: It is known that tobacco use causes several detrimental effects to one's health. It is advised to stop tobacco use. There are various methods to assist in tobacco use cessation including over-the-counter nicotine patches and gums, or oral prescriptions therapy from your primary care provider.

Personal Alcohol Use: How many times in the past year have you had 5 (for men) or 4 (women or all over 65 years) or more drinks in a day? _____

*Have you had the **flu vaccine**, August 2019-March 2020?	☐ **YES**	☐ **NO**
*Have you ever had a **pneumococcal vaccine** (pneumovax)? *(This is recommended to receive once for 65 years and older)*	☐ **YES**	☐ **NO**

Please give this form to your nurse

Past Medical History **(Please Check)** **NONE OF THESE**

- ☐ Arthritis
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Colon Cancer
- ☐ Anxiety disorder
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Stroke
- ☐ Coronary Artery Disease
- ☐ Seizures
- ☐ GERD / Reflux
- ☐ Hearing Loss
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Bone Marrow Transplant

Other: _____

Past Surgeries **(please check)** **NONE OF THESE**

- ☐ Colon Resection (Colectomy)
- ☐ Coronary Artery Bypass Graft
- ☐ Transplant Kidney
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision Squamous Cell Carcinoma
- ☐ Colostomy
- ☐ Tubal Ligation
- ☐ Lumpectomy of the Breast
- ☐ Mastectomy of Left Breast
- ☐ Mastectomy of Right Breast
- ☐ Heart: Mechanical Valve Replacement
- ☐ Excision of Ovary
- ☐ Pancreas Excision
- ☐ Percutaneous Kidney Stone Removal
- ☐ Liver Shunting Operation

- [ ] Appendectomy (Appendix removal)
- [ ] Cholecystectomy (Gallbladder removal)
- [ ] Liver Excision
- [ ] PTCA: Angioplasty (Stent)
- [ ] Heart: Biological Valve Replacement
- [ ] Removal of Bladder (Cystectomy)
- [ ] Prostate (Prostatectomy): TURP
- [ ] Hysterectomy (Uterine Removal)
- [ ] Prostate Excision (Prostatectomy)
- [ ] Splenectomy (Excision of Spleen)
- [ ] Nephrectomy (Removal of kidney)
- [ ] Orchiectomy (Removal of Testicle)
- [ ] Joint Replacement: Hip (Both, Left, Right)
- [ ] Joint Replacement: Knee (Both, Left, Right)
- [ ] Heart Transplant
- [ ] Liver Transplant

Other surgeries:_____

Skin History

- [ ] Acne
- [ ] Actinic Keratosis
- [ ] Basal Cell Carcinoma
- [ ] Contact Dermatitis Poison Ivy
- [ ] Melanoma
- [ ] Atypical/ Precancerous Moles
- [ ] Eczema
- [ ] Hay fever/Allergies
- [ ] Flaking or Itchy Scalp
- [ ] Psoriasis
- [ ] Squamous Cell Skin Cancer
- [ ] Blistering Sunburns

Other: _____

Do you wear sunscreen? [ ] **YES** [ ] **NO** *SPF?* _____

Do you currently tan in a tanning salon? [ ] **YES** [ ] **NO**

Do you have a family history of Melanoma? [ ] **YES** [ ] **NO**

If yes, which family member or relative? _____

Allergies

Do you have any food or drug allergies? ☐ **YES** ☐ **NO** *If yes, please list below.*

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Social Status

What is your smoking status?

☐ Never smoked ☐ Former smoker ☐ Current smoker ☐ Cigar smoker

Illicit Drug Use?

☐ Yes ☐ No

IV drug Use:

☐ Yes ☐ No *(used in the last 12 months:* ☐ *Yes* ☐ *No)*

Do you consume alcohol?

☐ None ☐ 1 drink per day ☐ 1-2 drinks per day ☐ 3+ drinks per day

How often do you exercise?

☐ Never ☐ Once a day ☐ Several times a day ☐ Few times a week ☐ Few times a month

How often do you consume caffeine?

☐ Never ☐ Once a day ☐ Several times a day ☐ Few times a week ☐ Few times a month

Occupation and Workplace: _____

Do you feel safe at home?

☐ Yes ☐ No

City and State of residence: _____

Patient Information

Last Name	First Name	Middle Initial	Preferred Name

Date of birth		Marital status	Social Security Number
	☐ MALE ☐ FEMALE		

Emergency contact name	Relation	Emergency contact number

_____ ***May we leave you a detailed message?*** ☐ ***YES*** ☐ ***NO***

Preferred contact number

Home Phone number	Work Phone number	Cell phone number

_____

Email (for patient portal)

Permanent Mailing/Billing address	City	State	Zip Code

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Dermatology and Skin Cancer Institute or insurance company to release any information required to process claims.

X _____ _____

Signature **Date**

Insurance Information

Primary Insurance Name **Policy Holder's Name** **Holder's Date of Birth**

Secondary Insurance Name **Policy Holder's Name** **Holder's Date of Birth**

Pharmacy Information

Preferred Pharmacy Name

Address or Major Street

Provider Information

Primary Care Physician

Were you referred? ☐ **YES** ☐ **NO**

if yes, by who? _____

Privacy Policy

With your consent, ***Advanced Dermatology and Skin Cancer Institute*** may call, mail or email you regarding anything pertaining to your healthcare treatment, including payment and other operations such as appointment reminders. By singing this form, you use and disclosure of protected health information about you for the purposed of treatment, coverage and payment from your Health Insurance Company, and overall health care instances.

Telephone Communication: Please indicate if you would like for us to leave information regarding you care on your voicemail. Please initial by the option of your choice and including a phone number, and if you would like for us to leave detailed message regarding your healthcare, including lab or pathology results. **Phone Number preferred: _____**

_☐_ Leave a detailed message about my healthcare.

_☐_ Leave a message with a call back number only.

Persons Authorization to receive Information About Your Care

I authorize ***Advanced Dermatology and Skin Cancer Institute*** to release medical, appointment, and/or financial information over the telephone or in person to the following person(s):

1._____

First and last name Relationship Phone number

2._____

First and last name Relationship Phone number

Signature of patient or legal guardian: X_____ Date: _____

Consent for Examination, Treatment and Financial Responsibility Agreement

I hereby consent to and authorize the provider(s) and employees at ***Advanced Dermatology and Skin Cancer Institute*** to provide care to me during my office visits. I authorize the release of appropriate medical information for the purpose of processing insurance claims on my behalf. I understand that I am financially responsible for services provided which are to be paid on the date of service. I also understand that the filing of an insurance claim is not guarantee of payment, and that I am financially responsible for payment if a claim is unpaid or denied by the insurance company.

I authorize the release of my medical information to my primary care physician, referring physician, and/or consultants as necessary to carry out proper medical treatment. I understand that photography may be necessary for planning and evaluation treatment, and authorize taking photographs at the direction of the physician. This is solely for documentation purpose. They will be kept confidential unless otherwise disclosed.

Signature of patient or legal guardian: X_____ Date: _____