Skin Disease History

Acne	**Y**	**N**	**Flaking or itchy scalp**	**Y**	**N**
Actinic Keratosis	**Y**	**N**	**Hay Fever/Allergies**	**Y**	**N**
Asthma	**Y**	**N**	**Melanoma**	**Y**	**N**
Basal Cell Skin Cancer	**Y**	**N**	**Poison Ivy**	**Y**	**N**
Blistering Sunburns	**Y**	**N**	**Precancerous Moles**	**Y**	**N**
Dry Skin	**Y**	**N**	**Psoriasis**	**Y**	**N**
Eczema	**Y**	**N**	**Squamous Cell Skin Cancer**	**Y**	**N**

Other:_____

Do you wear sunscreen? Y N

If yes what SPF? _____

Do you use a tanning bed? Y N

Family history of skin cancer? Y N

Family history of malignant melanoma? Y N

If family history of melanoma, which relative? _____

<u>Past Medical History</u>

Anxiety	**Y**	**N**	**Hearing loss**	**Y**	**N**
Arthritis	**Y**	**N**	**Hepatitis**	**Y**	**N**
Asthma	**Y**	**N**	**High Blood Pressure**	**Y**	**N**
Irregular Heartbeat(A-FIB)	**Y**	**N**	**HIV/AIDS**	**Y**	**N**

Enlarged Prostrate	**Y**	**N**	**High Cholesterol**	**Y**	**N**
Thyroid Disorder	**Y**	**N**	**Breast Cancer**	**Y**	**N**
Colon Cancer	**Y**	**N**	**Leukemia**	**Y**	**N**
Lung Cancer	**Y**	**N**	**Lymphoma**	**Y**	**N**
Chronic lung disease	**Y**	**N**	**Heart Disease**	**Y**	**N**
Depression	**Y**	**N**	**Prostate Cancer**	**Y**	**N**
Kidney Disease/Failure	**Y**	**N**	**Radiation Treatment**	**Y**	**N**
Gastric Reflux(GERD)	**Y**	**N**	**Epilepsy**	**Y**	**N**

Other _____

Past Surgeries: Have you ever had surgery on the following organs

Appendix	**Y**	**N**	**Joint Replacement**	**Y**	**N**
Bladder	**Y**	**N**	**Kidney**	**Y**	**N**
Breast: Mastectomy	**Y**	**N**	**Breast:Lumpectomy**	**Y**	**N**
Colon	**Y**	**N**	**Ovaries**	**Y**	**N**
Gallbladder removed	**Y**	**N**	**Prostate**	**Y**	**N**
Skin: Basal cell	**Y**	**N**	**Skin: Squamous Cell**	**Y**	**N**
Skin: Melanoma	**Y**	**N**	**Heart (bypass surgery)**	**Y**	**N**
Heart valve replaced	**Y**	**N**	**Heart Angioplasty**	**Y**	**N**
Spleen	**Y**	**N**	**Testicles**	**Y**	**N**
Uterus (Hysterectomy)	**Y**	**N**	**Other_____**		

Social History

Alcohol Use	**Y**	**N**	**Former Smoker**	**Y**	**N**
2-3 drinks/day	**Y**	**N**	**Less than one drink/day**	**Y**	**N**
Drug use	**Y**	**N**	**IV Drug use**	**Y**	**N**
Smoker	**Y**	**N**	**Occasional Drink**	**Y**	**N**
Never smoked	**Y**	**N**			

Review of Symptoms

Problems with bleeding	**Y**	**N**	**Acne Problems**	**Y**	**N**
Problems with healing	**Y**	**N**	**New/Changing Lesion**	**Y**	**N**
Problems with scarring	**Y**	**N**	**Dry Skin**	**Y**	**N**
Rash	**Y**	**N**	**Unintentional weight loss**	**Y**	**N**
Immunosuppression	**Y**	**N**	**Thyroid problem**	**Y**	**N**
Hay fever	**Y**	**N**	**Sore throat**	**Y**	**N**
Blurry vision	**Y**	**N**	**Abdominal pain**	**Y**	**N**
Bloody stool	**Y**	**N**	**Bloody urine**	**Y**	**N**
Joint aches	**Y**	**N**	**Muscle weakness**	**Y**	**N**
Neck stiffness	**Y**	**N**	**Headaches**	**Y**	**N**
Seizures	**Y**	**N**	**Wheezing**	**Y**	**N**
Shortness of breath	**Y**	**N**	**Coughing**	**Y**	**N**
Chest pain	**Y**	**N**	**Fever or chills**	**Y**	**N**
Anxiety	**Y**	**N**	**Depression**	**Y**	**N**

Alerts

Allergy to adhesives	**Y**	**N**
Allergy to lidocaine	**Y**	**N**
Allergy to topical antibiotics	**Y**	**N**
Artificial heart valve (mechanical)	**Y**	**N**
Artificial joints in the past two years	**Y**	**N**
Blood thinners (other than aspirin)	**Y**	**N**
Defibrillator	**Y**	**N**
Pacemaker	**Y**	**N**
MRSA	**Y**	**N**
Rapid heart rate with epinephrine	**Y**	**N**
Pre-medication prior to procedures	**Y**	**N**
Pregnancy or planning a pregnancy	**Y**	**N**

Financial Policies for Dermatology Outreach, LLC

Self-Pay: I understand that if I do not have health insurance for payment is due at time of service.

Proof of Insurance : The practice must obtain a copy of my photo ID and current valid health insurance card. If I failed to provide Dermatology Outreach, with the correct insurance information, I will be responsible for the balance of the claim.

Changes in coverage: I understand that if my insurance changes I will notify Dermatology Outreach before my next visit so they can make appropriate changes to help me receive maximum benefits.

Policy Benefits/Non-Covered Services: I understand it is my responsibility to know my insurance policy coverage and benefits. I understand that some or all services may be non-covered, and I am personally responsible for any amounts not covered by my insurance. I also understand that routine in office procedures are billed separately from my office visit and may be subject to my deductible or additional co-pays.

Co-payments: I understand that all her payments are due at time of check-in before being seen by the provider.

Deductibles: I understand that if it is determined by my insurance policy has a unmet deductible, an estimate payment for services at the contracted rate between the provider and my insurer will be due at the time of service. Alternately, I may place a card on file for automatic payment once my insurance has determined my financial responsibility.

NO Show/Cancellations: I understand that if I do not cancel my appointment at least 24 hours in advance, or if I fail to appear for my appointment, Dermatology Outreach will assess a fee of $30 which must be paid before I can reschedule.

Referrals: I understand it is my responsibility to obtain any and all necessary referrals if my insurance plan requires them. Failure to obtain a referral, when required, will result in me bearing the complete financial responsibilities for any and all services received.

Assignment of Benefits/Authorization for Treatment: I hear by authorize treatment and assign directly to Dermatology Outreach all insurance benefits.

Payment for Ancillary Services (pathology): I understand that Dermatology Outreach utilizes the services of outside laboratories for pathology and microbiology. These laboratories will bill for services separately from Dermatology Outreach.

Claims Submission: I understand that my insurance company may need me to supply certain information directly. It is my responsibility to comply with their request. (For example, coordination of benefits)

Returned Checks: I understand that any returned check by my bank as unpaid will result in a $25 return check fee.

Past Due Accounts: Accounts are considered past due 30 days after statement date. Past due accounts must be paid before next scheduled services unless a payment plan has been previously arranged by contacting our office at 304-842-3341. Accounts with a history of past due payments will be required to enroll in automatic payments placing a card on file. Accounts that are 90 days past due without a payment plan established will be discharged from the practice.

By signing this Financial Policy Notice you acknowledge that you have read, understand and accept all the above policies.

Printed Name: _____DOB:_____

Signature:_____Date:_____

Patient Information

Patient's Last Name _____First Name _____M.I___

Mailing Address_____City_____State_____Zip____

Home phone _____Cell_____Work _____

Email address _____

Date Of Birth _____/_____/_____ Age_____ Social Security #_____

Sex: M F Material Status: M S D if married spouse's name_____

If child- Name of mother and father or legal guardian_____

Primary Care Physician:_____Phone Number:_____

Emergency Contact:

Name:_____Phone Number:_____

Relationship to Patient:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE & PRIVACY PRACTICES FOR

DERMATOLOGY OUTREACH,LLC

I understand that under HIPAA (Health Insurance Portability and Accountability act of 1996) I have certain rights To privacy regarding my protected health information. I understand that this information can, and will be used to:

- **Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from third-party payers.**
- **Conducting normal healthcare operations, such as quality assessments and provider certifications.**

Patient/Responsible Party Signature _____