

PATIENT INFORMATION

PATIENT NAME: LAST FIRST MI		SOCIAL SECURITY NUMBER	
MAILING ADDRESS: STREET/PO		DATE OF BIRTH:	SEX (CIRCLE) FEMALE MALE
CITY: STATE: ZIP CODE:		HOME #:	CELL #:
EMAIL ADDRESS:		MARITAL STATUS: (CIRCLE) SINGLE DIVORCED MARRIED WIDOW PARTNER	
RACE: (CIRCLE). CAUCASIAN. AMERICAN INDIAN. ALASKAN NATIVE. ASIAN. AFRICAN AMERICAN. NATIVE AMERICAN. PACIFIC ISLANDER OTHER PRIMARY LANGUAGE SPOKEN? _____		ETHNICITY: (CIRCLE) HISPANIC. NON HISPANIC	
2 ND SEASONAL ADDRESS: STREET/PO. APT#. CITY. STATE. ZIP CODE			

PERSON RESPONSIBLE FOR CHARGES

<p>If the person responsible for payment is different from the patient, then complete below. If the patient is a child, please indicate if parents are: (circle) Married Separated Divorced</p>	
FULL NAME:	SOCIAL SECURITY NUMBER
MAILING ADDRESS:	DATE OF BIRTH:
CITY: STATE: ZIP CODE:	PREFERRED NUMBER TO CONTACT:
PATIENT RELATIONSHIP TO RESPONSIBLE PARTY (CIRCLE): SPOUSE CHILD OTHER:	WORK PHONE:

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN:	NAME OF REFERRING PHYSICIAN:
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EMERGENCY CONTACT

IN CASE OF EMERGENCY NOTIFY: (FULL NAME)	PHONE:
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INSURANCE INFORMATION

<p align="center">PRIMARY INSURANCE:</p> NAME: _____ POLICY/ID# _____ GROUP# _____ DOB: _____ SS# _____ RELATIONSHIP TO PATIENT: _____	<p align="center">SECONDARY INSURANCE</p> NAME: _____ POLICY/ID# _____ GROUP# _____ DOB: _____ SS# _____ RELATIONSHIP TO PATIENT: _____
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By signing below, I (or my authorized representative), authorize A to Z Dermatology and their staff to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health.

This consent provides us with your permission to perform reasonable and necessary medical evaluations, examinations, diagnosis, testing, and treatment. By signing below, you are indicating that (1) you intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

PATIENT CONSENTS

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:** I hereby assign and authorize payment directly to A to Z Dermatology all insurance benefits, sick benefits, or injury benefits due because of liability of a third-party. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with A to Z Dermatology's regular rates and terms. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):** I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

3. **CONSENT TO RELEASE HEALTH INFORMATION:** I understand A to Z Dermatology uses an electronic medical record that contains information about my health from my past and current health care providers. I agree that this health information may be released through electronic medical records or by other means (for example, fax): (1) to A to Z Dermatology ; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities. I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

4. **NOTICE OF PRIVACY PRACTICES:** Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all my protected health information generated during office treatments.

5. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:** I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

6. **CONSENT TO PHOTO/VIDEO:** I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained in accordance with protected health information regulations.

7. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION: I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's medical record electronically as my photo identification.

8. COMMUNICATIONS: I consent to this Facility, its successors or assignees contacting me via the methods I provide below. I understand the communications may occur in any manner, including calls to my cell phone or landline, voicemails, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, or text messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. I understand that the Facility is not responsible for paying any charges I incur from being contacted at the telephone number(s) or email address(es) provided. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

9. VIDEOTAPING/RECORDING: I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

10. NO SHOWS: Patients who miss more than three appointments within a six-month period may be discharged from our practice.

11. CONTACT PREFERENCES: Please indicate below the contact phone numbers that you authorize A to Z Dermatology to leave a phone message at or indicate that you do not want phone messages left at any contact phone number.

- () Ok to leave a phone message with detailed health information at following phone number: _____
() Ok to leave a phone message with callback phone number only at the following phone number: _____
() Do NOT leave a phone message at any number.

If we have permission to share your information with anyone else, in case we cannot reach you by phone, please fill in their name and phone number below:

€ OK to discuss & disclose any/all clinical information.

Name and Relationship to Patient _____

Contact Phone Number Contact #1 _____ Contact #2 _____

I have read this document, indicated my preferred method of communication and agree to the terms for financial responsibility.

• I understand it is my responsibility to notify A to Z Dermatology of any changes to the communication permissions I have given in this document.

• I understand my responsibility for payment to A to Z Dermatology and have been given the opportunity to ask questions about it. If additional information is needed to ensure insurance coverage, I will provide it in an accurate and timely basis.

Signature _____ Date: _____

HISTORY AND INTAKE FORM

Patient Name:		DOB	AGE
CURRENT OR PAST MEDICAL HISTORY (MARK ALL THAT APPLY)			
Artificial Heart Valve/Infection	Artificial joint replacement Year: _____	<input type="checkbox"/> Cold sores/herpes	
Hepatitis, Type _____	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Organ Transplant: Organ: _____ Year: _____	
Pacemaker: Year: _____	Staph Bacterial Infection	<input type="checkbox"/> MRSA Infection	
Vasovagal Reaction (fainting)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	
High Cholesterol	Autoimmune Condition _____	<input type="checkbox"/> Hyperthyroid (high thyroid) <input type="checkbox"/> Hypothyroid (low thyroid)	
Other: _____			
Surgical Procedures (within the past 2 years)			
SKIN DISEASE HISTORY (PLEASE CHECK ALL THAT APPLY)			
<input type="checkbox"/> ACNE: HAVE YOU TAKEN ACCUTANE IN THE PAST? YEAR: _____	<input type="checkbox"/> DRY SKIN	<input type="checkbox"/> PRECANCEROUS MOLES:	<input type="checkbox"/> ACTINIC KERATOSIS
<input type="checkbox"/> ECZEMA	<input type="checkbox"/> PSORIASIS	<input type="checkbox"/> FLAKING/ITCHY SCALP	<input type="checkbox"/> BLISTERING SUNBURN
<input type="checkbox"/> HISTORY OF HAY FEVER:		<input type="checkbox"/> HISTORY OF ASTHMA:	
<input type="checkbox"/> HISTORY OF SKIN CANCERS: BASAL CELL CARCINOMA. SQUAMOUS CELL CARCINOMA MELANOMA		<input type="checkbox"/> FAMILY HISTORY OF MELANOMA WHICH RELATIVE(S)? _____	
DO YOU WEAR SUNSCREEN? YES NO SPF? _____		PREVIOUS RADIATION TREATMENT? YES. NO WHEN? _____ WHY? _____	
MEDICATIONS/DOSE DO NOT LEAVE BLANK!			
PROVIDED LIST TO OFFICE		NO MEDICATIONS	
LIST ALL MEDICATIONS TAKING IF NO LIST HAS BEEN PROVIDED:			

ALLERGIES (LIST ALL ALLERGIES)			

NO KNOWN DRUG ALLERGIES: _____

SOCIAL HISTORY (CIRCLE OR MARK ALL THAT APPLY)

CURRENT SMOKER		FORMER SMOKER	<input type="checkbox"/> NEVER SMOKER
# OF ALCOHOLIC DRINKS PER DAY: _____	SEXUALLY ACTIVE: YES NO	MULTIPLE PARTNERS: YES NO	IV DRUG USE: YES. NO

REVIEW OF SYSTEM: Are you experiencing any of the following?

<input type="checkbox"/> PROBLEMS WITH BLEEDING	<input type="checkbox"/> PROBLEMS WITH HEALING	<input type="checkbox"/> PROBLEMS WITH SCARRING
<input type="checkbox"/> CHANGING MOLE	<input type="checkbox"/> RASH	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> IMMUNOSUPPRESSION	<input type="checkbox"/> THYROID PROBLEMS	JOINT PAIN
<input type="checkbox"/> UNINTENTIONAL WEIGHTLOSS	CHEST PAIN:	OTHER:

ALERTS (check all that apply)

<input type="checkbox"/> ALLERGY TO ADHESIVE	ALLERGY TO LIDOCAINE	<input type="checkbox"/> DEFIBRILLATOR	PACEMAKER
<input type="checkbox"/> BLOOD THINNERS	<input type="checkbox"/> PREGNANT	<input type="checkbox"/> RAPID HEARTBEAT TO EPINEPHRINE?	<input type="checkbox"/> GI UPSET

HAVE YOU RECEIVED ANY OF THE FOLLOWING VACCINATIONS (check all that apply)

<input type="checkbox"/> FLU (OCT-MAR)	<input type="checkbox"/> PNEUMONIA (65+ ONLY)	<input type="checkbox"/> SHINGLES (50+ ONLY)	<input type="checkbox"/> COVID
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PHARMACY INFORMATION:

PHARMACY NAME:	ADDRESS OR CROSS STREETS	PHONE NUMBER
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I hereby certify that the above information is true and correct to the best of my knowledge.

 Patient/Guardian Name (PRINT)

 Patient/ Guardian Signature

 Date