NEW PATIENT FORMS. Please PRINT

Patient Name: _____ Nickname/AKA:_____

Date of Birth: _____/_____/_____ Sex: M / F Marital Status: _____

Home #: _____ Cell #: _____ Contact Preference: Home / Cell

Occupation: _____ Pharmacy: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address (for Patient Portal Access): _____@_____

Primary Care Provider: _____ Referring Provider: _____

Emergency Contact/Relationship: _____ Phone Number: _____

(If patient is a minor)

Guarantor Name/DOB: _____ Relationship to Patient: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE INFORMATION

Ins Co Name: _____ Policy/Member ID #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Sex: M / F Patient Relationship to Insured: Self / Spouse / Child / Other: _____

SECONDARY INSURANCE INFORMATION

Ins Co Name: _____ Policy/Member ID #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Sex: M / F Patient Relationship to Insured: Self / Spouse / Child / Other: _____

****Military/Veterans: Sponsor's Name, DOB, & SSN are required for Insurance Verification & Payment****

Today's Date: ___/___/_____ Name: _____ Birth Date: ____/____/_____

Medical History Questionnaire

The reason for today's visit: _____

Present for how long? _____

Personal Dermatological History - Please check if you have a history of:

☐ Skin Cancer

Which Type?

☐Melanoma- When? _____ Body Location?_____ ☐Basal Cell Cancer- When? _____ Body Location? _____

☐Squamous Cell Cancer- When? _____ Body Location?_____

☐ Actinic Keratosis (Precancerous Skin Growth)

☐ Eczema ☐ Psoriasis ☐ Lupus ☐ Scarring Acne

☐ Other Dermatologic Condition(s)_____

☐ **NONE**

Medical History - Please check if you have a history of:

☐Allergies/Sinusitis
☐Artificial Heart Valve
☐Asthma
☐Bleeding Disorder
☐Cancer (Other than skin cancer)
Which type?
_____
☐Cataracts
☐Cold Sores (Herpetic Infection)
☐Congestive Heart Failure
☐Depression
☐Diabetes
☐Diabetes Mellitus
☐Emphysema/COPD
☐Epilepsy
☐GERD/(Reflux Disease)
☐Glaucoma
☐Heart Arrhythmia
☐Heart Disease
☐Hepatitis
☐High Cholesterol
☐HIV or Aids
☐Hypertension
☐Defibrillator
☐Irritable Bowel Syndrome
☐Mitral Valve Prolapse
☐Organ Transplant
☐Osteoarthritis
☐Osteoporosis
☐Pacemaker
☐Rheumatic Fever
☐Rheumatoid Arthritis
☐Stomach Ulcer
☐Thyroid Disease
☐Tuberculosis
☐Other
_____
☐ **NONE**

For Women:

Are you currently pregnant OR actively trying to get pregnant OR breastfeeding? ☐Yes ☐No

***Childhood Vaccinations*:**

☐HPV Vaccine ☐Td/Tdap ☐ Meningococcal vaccine ☐ VACCINES UP TO DATE

Annual vaccinations:

☐Flu vaccine **this** year ☐Pneumonia vaccine **this** year

☐Flu vaccine **last** year ☐Pneumonia vaccine **last** year

Social History

Do you wear sunscreen regularly? ☐Yes ☐No

Use tanning beds? ☐Yes ☐No

Do you smoke? ☐Yes ☐No

Drink alcohol? ☐ Yes ☐ No

Use drugs? ☐ Yes ☐ No

Do you have an Advanced Healthcare Directive in place? ☐ Yes ☐ No

PLEASE NOTE: Questions indicated with an "*" indicate we are required to ask this question by the Centers for Medicare Services (CMS) which is a federal agency that provides oversight and regulation in the healthcare community to improve outcomes and quality of care.

Family History - Do any family members suffer from the following? ☐ **Check Here if NONE**

Condition	Family Member (Relationship)
Skin Cancer (Other than Melanoma)	
Melanoma	
Asthma/Eczema/Seasonal Allergies	

ALLERGY LIST

MEDICATION/FOOD ALLERGIES	REACTION

****Any allergy to (check all that apply):**

Adhesive ☐Yes ☐No
Antibiotic Ointment ☐Yes ☐No
Epinephrine ☐Yes ☐No
Lidocaine ☐Yes ☐No
Latex ☐Yes ☐No

Please Initial for **No Known Drug Allergies**: _____

CURRENT MEDICATIONS/SUPPLEMENTS – *Let us know if you need more space*

Medication Name	Medication Strength	Dose (How Many)	Dose Form (tablet, capsule, etc.)	Medication Frequency (How many times per day)

Please Initial for **No Current Medications:** _____

I hereby certify that the above information is true and accurate, to the best of my knowledge.

_____ _____ _____

Patient/ Guardian Signature Patient/Guardian Print Name Date

Relationship if other than patient: _____

Complete Dermatology Financial Policies

I hereby certify that I have been provided with the Complete Dermatology Financial Policy, that I have had the opportunity to review its policies and agree to abide by the terms set forth in the document.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Patient or Responsible Party **PRINTED Name**

PRIVACY POLICIES AND HIPAA

I acknowledge that Complete Dermatology has made the Notice of Privacy Practices available to me. I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorized payment of medical benefits to the physicians.

_____ _____

Signature of Patient or Authorized Representative Date

Relationship if other than patient: _____

COMPLETE DERMATOLOGY

COMMUNICATIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that communication or PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving lab or procedure results with a designated person. I wish to be contacted in the following manner.

Best Phone number: _____

- ☐ Leave a message with a call back number only
- ☐ Leave medical information with my spouse, parent, family member
  Name: _____
- ☐ Do not leave a message
- ☐ Leave a message with detailed information including medical information

Please list any other individuals that are authorized to discuss information regarding medical/billing and/or scheduling (Please print authorized person(s) name/relationship):

_____

_____

_____

APPOINTMENT CONFIRMATIONS:

- ☐ Phone Call Only
- ☐ Text Message
- ☐ Email

EMAIL OPTIONS

- ☐ Appointments
- ☐ Practice Information and Updates
- ☐ Promotions, Events and Specials

****This Consent will remain in effect unless otherwise revoked in writing. ****

_____ _____

Signature of Patient or Authorized Representative Date

COSMETIC CONCERNS (OPTIONAL)

Complete Dermatology has the most advanced and comprehensive technology on the island for addressing a wide range of skin concerns. If you are interested in learning more about these technologies and how they can benefit you, please indicate below. More information can also be found on our website:

Check all that apply:

____ Fine Lines	____ Oily Skin	____ Deep Wrinkles
____ Acne / Breakouts	____ Skin Texture	____ Thin Lips
____ Facial / Body Hair	____ Redness/Rosacea	____ Tattoo removal
____ Nasolabial Creases	____ Scars	____ Facial Veins
____ Brown Spots	____ Saggy Skin	

Comments/Other concerns: