Medical History and Intake Form

Patient Name: _____ **Date of Birth (MM/DD/YYYY):** _____

Email Address: _____

Reason for visit, location and duration of problem: _____

_____

Past Medical History: (Check all that apply. If NONE, please check NONE)

- ○ Allergies (Seasonal)
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorder (or bleeding issue)
- ○ Cancer: _____
- ○ COPD
- ○ Coronary Artery Disease
- ○ Depression
- ○ Diabetes
- ○ GERD
- ○ Heart Failure
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ HIV/AIDS
- ○ Joint Replacement (last 2 years)
- ○ Kidney Transplant
- ○ Leukemia
- ○ Liver Disease
- ○ Lumpectomy
- ○ Lupus
- ○ Mastectomy
- ○ Organ Transplant
- ○ Seizures
- ○ Stroke
- ○ Thyroid Disease (hyper / hypo)
- ○ **NONE**

Do you have a history of Skin Cancer or Skin Disorders? (Examples: acne, actinic keratosis, basal cell, melanoma, psoriasis, squamous cell)

Yes _____ No _____ If yes, please indicate condition or disorder:

_____

Family History of Skin Cancer including Melanoma? Yes _____ No _____

If yes, whom: _____

Do you wear Sunscreen? Yes _____ SPF _____ No _____

Medications: (All current medications including non-prescription and birth control; if none mark N/A)

_____

_____

_____

Allergies: (Please list any allergies that you have, and the reaction you had. If none mark N/A)

_____

Surgeries: (List all past surgeries and approximate year; if none mark N/A)

_____

_____

Social History:

Non-Smoker Former Smoker Current Smoker **Alcohol:** 0-1 per day 2-3 per day If 4+ per day how many times in the past year? _____

Review of Systems: (Check all that apply)

- ○ Problems with bleeding
- ○ Problems with healing
- ○ Problems with scarring/keloids
- ○ Fever Chills
- ○ Night sweats
- ○ Unintentional weight loss
- ○ Joint Pain

Race

- ○ American Indian or Alaskan Native
- ○ Asian
- ○ Black/African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other Race _____
- ○ Decline to specify

Ethnic Group

- ○ Hispanic
- ○ Latino
- ○ Not Hispanic or Latino
- ○ Unknown
- ○ Decline to specify

Alerts: (Check all that apply. If NONE, please check **NONE**)

- ○ Allergy to Adhesive
- ○ Allergy to Lidocaine
- ○ Allergy to Topical Antibiotics
- ○ Artificial Heart Valve
- ○ Artificial Joint Replacement
- ○ Blood Thinners
- ○ **COPD**
- ○ **Coronary Artery Disease**
- ○ Defibrillator
- ○ **Diabetes**
- ○ **Heart Failure**
- ○ MRSA
- ○ Pacemaker
- ○ Require pre-op antibiotics
- ○ Rapid heartbeat with Epinephrine
- ○ Pregnant or trying to get pregnant?
- ○ Breastfeeding
- ○ **NONE**

Preferred Pharmacy: _____ **Location:** _____

Patient Registration Form

Patient Information

Patient's Legal Name: First Middle Last	Patient Date of Birth (MM/DD/YYYY): Social Security Number: Patient Gender (circle): Male / Female
Mailing Address (Street, City, State, ZIP):	Marital Status: Occupation:
Email Address: Home Phone Number:	Employer:
Cell Phone Number:	Employer Phone Number:
Referred to Clinic By (Please Circle): Dr. _____ / Family/Friend / Insurance Company / Web Search / Print Ad / Other: _____	
Primary Care Physician (PCP) Name:	PCP Phone Number (If Known):

Responsible Party Information (Spouse / Parent / Legal Guardian)

Guarantor on Account (eg, responsible parent if patient is a minor):	Guarantor Phone Number:	Guarantor Relationship to Patient:
Guarantor Date of Birth (MM/DD/YYYY):	Guarantor Mailing Address (Street, City, State, Zip):	

Insurance Party Information

Primary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's DOB:	Relationship to Patient:
Specialist Copay Amount: $ _____		
Secondary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's DOB:	Relationship to Patient:

Emergency Contact (Please list anyone you authorize to receive protected health care and/or financial information)

Name:	Relationship to Patient:	Access to Information	Phone Number:
		Health: Y N Financial: Y N	
		Health: Y N Financial: Y N	

Legal Information

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Ricks Advanced Dermatology and Skin Surgery and its related companies. I understand that I am financially responsible for any balance. I also authorize Ricks Advanced Dermatology and Skin Surgery, its related companies, or insurance company to release medical information required to process claims.

Notice of Privacy Practices: I have read or been offered a copy of Ricks Advanced Dermatology and Skin Surgery's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.

Consent for Communication: I understand Ricks Advanced Dermatology and Skin Surgery will send appointment reminders and information on services via telephone, email and/or text message based on contact information I provided. I understand that I will have the option to opt out of future text/email reminders.

Payment Policy: Payment is due at time of service including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Ricks Advanced Dermatology and its related companies.

Legal: This form applies to Ricks Advanced Dermatology and its related companies.

Signature

Patient/Guardian Signature:	Date: