Please complete and bring to your appointment with insurance card(s)

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)**
- ○ Leukemia
- ○ Liver Disease
- ○ Lupus
- ○ **Organ Transplant/Immunosuppression**
- ○ Seizures
- ○ Stroke
- ○ Thyroid Disease (hyper / hypo)
- ○ Other: _____
- ○ **NONE**

History of Skin Cancer or Skin Disorders? (Examples: acne, actinic keratosis, basal cell, eczema, melanoma, psoriasis, squamous cell)

_____

Family History of MELANOMA Skin Cancer? Yes _____ No _____

If yes, whom: _____

Do you wear Sunscreen? Yes _____ SPF _____ No _____ **Tanning Bed Use:** Yes _____ No _____

Social History:

Smoking: ☐ Non-Smoker ☐ Former Smoker (quit year) _____ ☐ Current Smoker or E-cigarette (vaping) ☐ Smokeless tobacco

Alcohol: ☐ None ☐ <1 per day ☐ 1-2 per day ☐ 3 or more per day If 3+ per day how many times in the past year? _____

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

_____

_____

_____

Medication AND Environmental 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)

_____

_____

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: _____
- ○ 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 (last 2 years)**
- ○ 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 (Please complete ALL areas on form)

Patient Information

Patient Informations

Patient's Legal Name: (**Nickname**):
First Middle Last

Primary Care Provider:

Last Visit with PCP (date):

Billing Preference: **ONLINE** OR **PAPER STATEMENT**

Patient Mailing Address:

City: **State:** **Zip:**

Patient Date of Birth:

Social Security #:

Referred to clinic by: Dr. _____
Family Friend / Ins. Co. / Web Search / Print Ad
Other:

Email:

Patient Sex: **Male / Female**
Marital Status: **Single** **Married** **Divorced** **Widowed**

Cell Phone Number: ( ) **Home Phone Number**: ( )

Preferred Automated Appointment Reminder Method (in addition to phone call): **Text** **E-mail**

Employer: Occupation: Work phone #: ( )

Responsible Party Information (Parent / Legal Guardian / Spouse) ***Self if age 18 or older***

Guarantor on Account (eg, responsible party for minors)	Relationship:	Guarantor's SS #
Guarantor Date of Birth (MM/DD/YYYY):	Guarantor Mailing Address (Street, City, State, Zip):	
Guarantor Employer:	Guarantor Work phone #:	

Insurance Party Information ***Copayments are expected at time of service

Certain Managed Care insurance options required a referral. It is patient responsibility to obtain this authorization prior to services rendered.

Primary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's DOB:	Policyholder's SS #
Specialist Copay Amount: $ _____	Insurance through (employer name)	Relationship to patient:
Secondary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's DOB:	Policyholder's SS#
Specialist Copay Amount: $_____	Insurance through (employer name)	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 Care Proxy (Advanced Directives)

Do you have a Durable Power of Attorney for Health Care decisions? Y N	Do we have a copy of that form? Y N
Do you have a Living Will? Y N	Do we have a copy of that form? 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 and Benign Test Results 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 have read and agree with the Office & Payment Policies. 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.

Treatment of minor: My signature below gives my consent to medical treatment of minor child, and consent to see minor child if they present for appointment without my attendance.

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

Patient Signature: Date: