DEMOGRAPHICS/DISCLOSURE FORM

PRACTICE LIMITED TO DISEASES OF SKIN AND HAIR.

First name________________________________Middle name____________________________________
Last name_________________________________Sex M/F Date of Birth_____/____/__________

EMAIL:____SOCIAL No________/______/_____________

Phone NO: Home________________________Cell_______________________Work__________________
Preferred Phone: (circle one) HOME / WORK / CELL/EMAIL

Address____

City__________________________County_____________State___________________ZIP Code_________

Ethnicity________________Language_______________Race______________________________________

IN EMERGENCY CALL MY____________NAME________________________PH_______________________

INSURANCES **PRIMARY** **SECONDARY**

Name of company: ______________________________ ____

Insured name: ______________________________ ____

Relationship to patient: _________________________ ____

Co-pay Amount: ______________________________ ____

Policy No/ID: ______________________________ ____

Group No/ID: ______________________________ ____

Employer: ______________________________ ____

Primary insurance holder's name__________________________________Date of birth___/____/_______

DISCLOSURE OF INFORMATION ABOUT YOUR MEDICAL CONDITIONS
I authorize Maryland Skin Care Centers, LLC to disclose any information concerning my care or treatment by providers to the following individuals

____

____

Your Primary Care Physician will be informed if you write their name here
My primary care is____ ☐ I DONOT HAVE A PRIMARY CARE PHYSICIAN

Sign:____Date:_____/_____/_______________

Print your name: ____
Relation to Patient: (circle one) Self / Mother / Father / Legal Guardian

JAGADEESH KUMAR MD MRCP
PRACTICE LIMITED TO DISEASES OF SKIN AND HAIR

Dermatology Medical History Form

Date:___/____/_________Patient Name____

Date of Birth _____/____/______Sex_________ Age_____ Height___ft___inches Weight______lbs

WOMEN Are you Pregnant ? circle one **YES / NO**

Are you Breast feeding ? **YES / NO**

Are you required to take antibiotics before surgical procedure **YES / NO**
Artificial joints / Heart Valve / Pacemaker / Immunosupressed

Are you allergic to any medications? **YES / NO** If yes please list below:
____

Current Pharmacy Name and Address:____
____

List ALL medications you are currently taking (including prescriptions, over the counter, vitamins, and herbals):

1.________________________ 2.________________________ 3.______________________

4.________________________ 5.________________________ 6.______________________

7.________________________ 8.________________________ 9._____________________

Do you have now, or have you ever had any of the following diseases or conditions:
(please circle Y for yes and N for no)

Lungs:	YES	NO
Bronchitis	Y	N
Emphysema	Y	N
Asthma	Y	N
Chronic Cough	Y	N
Morning Cough	Y	N
Shortness of Breath	Y	N
Wheezing	Y	N

Cardiovascular:	YES	NO
High Blood Pressure	Y	N
Chest Pain	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Irregular Heartbeat	Y	N
Phlebitis	Y	N
Inflammation of vein	Y	N
Blood clots	Y	N
Seizures	Y	N
Pacemaker	Y	N

Others :	YES	NO
Diabetes	Y	N
Excessive thirst/hunger	Y	N
Thyroid	Y	N
Kidney	Y	N
Bladder	Y	N
Frequency/Burning	Y	N
Gastrointestinal/Stomach absorptive disorder	Y	N
Nausea, vomiting, diarrhea when taking antibiotics	Y	N
Yeast infection when taking antibiotics	Y	N
Arthritis/Joint Deformity	Y	N
Arthralgia	Y	N
Limited Motion	Y	N
Artificial joint	Y	N
Convulsions, Epilepsy, or Fainting	Y	N

Do you bleed easily? YES NO

List the Surgeries You had in past:____
____
____

JAGADEESH KUMAR MD MRCP
PRACTICE LIMITED TO DISEASES OF SKIN AND HAIR

SKIN : (please circle your answer)

When you are exposed to sun do you: Tan only Tan and burn Burn

Have **you** ever had skin cancer? Yes No
Malignant Melanoma? Yes No

Has anyone in your **family** had skin cancer? Yes No
Malignant Melanoma? Yes No

If yes, who?____

Do you have a history of any specific skin disease? YES NO
If yes, please list:____
____
____

Are you currently receiving any treatment for any specific skin diseases? YES NO

If yes, please list any treatment, including the name of the physician treating you and any medications you are currently using (prescription, over the counter, or herbal):_______________________________

____

Do you develop skin rashes in reaction to _____Food or _____Environment?
If yes, please list any know foods or environmental factors that produce rashes:__________________

____

List any other diseases or conditions:____

Social History: (circle your answer)
Do you drink alcohol? YES NO If yes,__________drinks per day.
Do you use IV drugs? YES NO If yes, what?_________How much?_____
Do you smoke? YES NO If yes,_________packs per day.
Do you have AIDS or have you ever been exposed to HIV(AIDS)? YES NO

What is your occupation?____

What are your hobbies?____

_______________________________________ _______________________________________
Patient or Guardian signature Date Reviewed by Date

UPDATES SIGN AND DATE IF NO CHANGES

________________ **Date**____/____/________	________________ **Date**____/____/________
________________ **Date**____/____/________	________________ **Date**____/____/________
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JAGADEESH KUMAR MD, MRCP.

PRACTICE LIMITED TO DISEASES OF SKIN AND HAIR.

I undersigned, consent to the use and disclosure of my protected health information for the treatment, payment, operations, and such other purposes that are permitted under the federal Health Insurance Portability and Accountability act without a written authorization.

I accept that I am financially responsible for all the services rendered on my behalf by Maryland skin care centers LLC. For those insurance plans for which the Practice accepts assignment, I accept personal responsibility for all Co-payments, Deductibles, and Non-covered services, as dictated by my insurance coverage.

I accept financial responsibility for all fees incurred including any collection/attorney fees the Practice incurs in collecting payments for which I am responsible. I authorize the entities above or the designated representatives to charge additional amounts that may be incurred in the collection of any unpaid debts.

MARYLAND SKIN CARE CENTERS, LLC. is a practice limited to the care of diseases of the skin and prevention of skin cancers, I will seek care of medical diseases and preventive medical care with my own Primary Care Physician.

I promise to follow medical recommendation made by my physicians and the staff who treat me. In the event I do not follow up with the recommended treatment plan made by my providers, I fully accept the consequences of my failure do so and fully release all providers, staff and the organizations associated with my care from all the present and future liability and promise to accept full responsibility for my actions.

In the event that I fail my responsibility to follow the recommended medical advice and a claim arises against the providers, I promise to reimburse any costs incurred by my providers, staff and entities in defending such a liability claim.

I authorize payment directly to the Practice for the services for which the practice accepts the assignment and I do understand 100% guarantee cannot be made about the effectiveness of the treatments provided to me. A copy of this agreement can be used in the place of the original.

I certify the information stated on this form is correct.

____ Dated____/____/_________

Signature of the Patient/Parent/legal Guardian

____ Relation ______________________

Print name