Island
DERMATOLOGY LLC

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INTAKE AND HEALTH HISTORY FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: ____ Preferred Name: _____

Marital Status: _____ Date of Birth: _____ SSN: _____

Birth Sex (circle one): MALE FEMALE Race: _____ Language: _____

Ethnic Group (circle one): HISPANIC/LATINO NOT HISPANIC/LATINO DECLINE TO ANSWER

PATIENT CONTACT INFORMATION:

Patient Home Phone#: _____ Patient Mobile Phone#: _____

Email address: _____ Spouse Full Name: _____ Phone#: _____

Mailing Address: _____ City/State: _____ Zip: _____

Emergency Contact Full Name: _____ Phone#: _____ Relationship to Patient: _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION:

If person responsible for payment is different from the patient, please complete the section below.

Is the patient a minor (circle one)? YES NO Patients relationship to Guarantor: _____

Guarantor's Last Name: _____ Guarantor's First Name: _____

Contact Information same as Patient's (circle one)? YES NO If NO, please complete below:

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone#: _____ Mobile Phone#: _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy/Subscriber ID#: _____ Group#: _____

Patient's relationship to Subscriber: _____

Secondary Insurance Carrier: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy/Subscriber ID#: _____ Group#: _____

Patient's relationship to Subscriber: _____

PHARMACY

Pharmacy Name: _____ Pharmacy Location: _____

PRIMARY CARE PROVIDER

PCP Name: _____ Office Phone#: _____

If Referred by Provider, please list Provider Name: _____ Office Phone#: _____

PAST MEDICAL CONDITIONS:

Please check the box of any of the following medical conditions you have had or that you currently have or check NONE.

☐ None	☐ Human immunodeficiency virus infection
☐ Anxiety disorder	☐ Hypercholesterolemia
☐ Arthritis	☐ Hyperthyroidism
☐ Asthma	☐ Hypothyroidism
☐ Atrial fibrillation	☐ Inflammatory disease of liver
☐ Cerebrovascular accident	☐ Leukemia
☐ Chronic obstructive lung disease	☐ Malignant lymphoma
☐ Conjunctivitis	☐ Malignant tumor of breast
☐ Coronary arteriosclerosis	☐ Malignant tumor of colon
☐ Depressive disorder	☐ Malignant tumor of lung
☐ Diabetes mellitus	☐ Malignant tumor of prostate
☐ Elevated blood pressure	☐ Radiation therapy treatment management
☐ End-stage renal disease	☐ SARS coronavirus
☐ Epilepsy	☐ Total replacement of left hip joint
☐ Gastroesophageal reflux disease	☐ Total replacement of left knee joint
☐ Generalized anxiety disorder	☐ Total replacement of right hip joint
☐ H/O: hypertension	☐ Total replacement of right knee joint
☐ Hearing Loss	☐ Total shoulder replacement
☐ Human herpes simplex virus type 1	☐ Transplantation of bone marrow
☐ Human herpes simplex virus type 2	☐ Other _____

PAST SURGICAL HISTORY:

Please check the box of any of the following surgeries you have had or check NONE.

☐ None	☐ History of transurethral prostatectomy
☐ Abdominoperineal resection	☐ Hysterectomy
☐ Biopsy of breast	☐ Kidney biopsy
☐ Biopsy of prostate	☐ Low anterior resection of rectum
☐ Coronary artery bypass graft	☐ Lumpectomy of breast
☐ Endoscopic carpal tunnel release	☐ Mastectomy of left breast
☐ Entire transplanted kidney	☐ Mastectomy of right breast
☐ Excision of basal cell carcinoma	☐ Mechanical heart valve replacement
☐ Excision of melanoma	☐ Oophorectomy
☐ Excision of squamous cell carcinoma	☐ Pancreatectomy
☐ H/O: colostomy	☐ Percutaneous extraction of kidney stone with
☐ H/O: tubal ligation	☐ Portosystemic shunt operation
☐ History of appendectomy	☐ Prostatectomy
☐ History of bilateral mastectomy	☐ Splenectomy
☐ History of cholecystectomy	☐ Surgical biopsy of skin
☐ History of colectomy	☐ Total nephrectomy
☐ History of liver excision	☐ Total orchidectomy
☐ History of percutaneous transluminal	☐ Transplantation of heart
☐ History of tissue graft heart valve	☐ Transplantation of liver
☐ History of total cystectomy	☐ Other

SKIN CONDITIONS:

Please check the box of any of the skin conditions you have had or that you currently have or check NONE.

☐ None	☐ H/O: hay fever
☐ Acne	☐ Malignant melanoma
☐ Actinic keratosis	☐ Pruritus of scalp
☐ Basal cell carcinoma of skin	☐ Psoriasis
☐ Contact dermatitis due to poison ivy	☐ Seborrheic dermatitis
☐ Dry skin	☐ Squamous cell carcinoma
☐ Dysplastic nevus of skin	☐ Sunburn of second degree
☐ Eczema	☐ Other _____
☐ H/O: asthma	

SKIN PROTECTION:

Do you wear sunscreen (circle one)? YES NO If YES, what SPF? _____

Do you tan in a tanning salon (circle one)? YES NO

FAMILY HISTORY OF MELANOMA:

Do you have a family history of Melanoma (circle one)? YES NO

☐ None	☐ Aunt
☐ Mother	☐ Nephew
☐ Father	☐ Niece
☐ Sister	☐ Grandmother
☐ Brother	☐ Grandfather
☐ Daughter	☐ Grandson
☐ Son	☐ Granddaughter
☐ Uncle	☐ Other _____

MEDICATIONS:

Please list all current medications or provide a medication list to your provider. Please include frequency and dose.
1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES:

Please list all allergies and reactions if known:
1. _____
2. _____
3. _____

SOCIAL HISTORY:

Smoking Habits - What is your smoking status? Please check one of the following:

- ☐ Never smoker
- ☐ Current every day smoker
- ☐ Current some day smoker (tobacco)
- ☐ Current some day smoker (cigarette)
- ☐ Former smoker
- ☐ Smoker, current status unknown
- ☐ Cigar smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker

Alcohol and Drug Use - How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you consume alcohol (EtOH or grain alcohol)? Please check one of the following:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 Drinks per day
- ☐ 3 Or more drinks per day

Any illicit drug use?

- ☐ Yes If Yes, please list: _____
- ☐ No

Driving status - Check all that apply:

- ☐ Drives in the Daytime
- ☐ Drives in the Night

Exercise Status - Check the box of the frequency that best applies:

- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other: _____

Caffeine Usage - Check the box of the frequency that best applies:

- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other: _____

If you are 65+ years of age, please answer the following:

Do you have a health care proxy in the event you are unable to make your own medical decisions?

- ☐ Yes
- ☐ No

How did you hear about us (circle one): INSURANCE GOOGLE OUR WEBSITE

PHYSICIAN REFERAL PATIENT REFERRAL OTHER: _____

ISLAND DERMATOLOGY LLC
CONSENT TO CLINICAL PROCEDURES

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, surgical removals, or excisions), or other services rendered during my visit with Island Dermatology LLC.

To ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns, and goals with you in regard to the following:

- Benefits of the proposed procedure.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen will be sent to a pathology lab for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges.

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly.

With any procedure, there are risks involved which include, but are not limited to the following:

- Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed.
- Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage – This will be thoroughly discussed with you by your physician if it is a potential during your procedure.
- I authorize pictures to be taken before, during and after the procedure. These pictures will become part of your medical record. They may also be sent to your family physician and/or referring physician. They will not be used for any other purpose without a proper consent.

If a complication after the procedure would arise, there may be a charge for the medical management that will be submitted to your insurance company. I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Island Dermatology LLC. I do not impose any limitations on Island Dermatology LLC and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

_____ _____

Patient Printed Name Patient Signature / Date

The undersigned hereby provides consent as the ***parent or guardian*** *of the above referenced minor patient.*

_____ _____ _____

Parent or Guardian Printed Name Parent or Guardian Signature / Date Relationship to Patient

ISLAND DERMATOLOGY LLC - PATIENT FINANCIAL POLICY

Welcome and thank you for choosing Island Dermatology LLC for your dermatology care. Your clear understanding of your **Patient Financial Policy** is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

Insurance: When making an appointment with your physician, it is **your responsibility** to confirm with your insurance company that the physician is currently under contract with the plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral at the time of your appointment. If you do not have your referral at the time of your appointment or do not have active insurance, you will need to reschedule your appointment or choose to be seen **without the insurance benefits and pay for your visit in full**.

You are responsible for knowing your insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 90 days from the date the claim is filed for the insurance company to pay. If the insurance company does **NOT** pay within this time, **you will be** responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered service, co- insurance, coordination of benefits, or pre-existing conditions. You are responsible for all co-payments and deductibles **at time of service**.

Check-In: Please bring your current insurance card and government issued photo ID with you to **EACH** visit. Without the insurance card, we will be unable to file your insurance, and **you will be responsible** for all charges for that visit. On follow-up visits you will be asked to verify all demographic and insurance information so that our records remain up to date.

Check-Out: Please be **prepared to pay** for the current visit as well as any past balances on your account. Payment and copayments, deductibles, or fees for non-covered services will be required at the time of service. For your convenience we take cash, check, and all major credit cards.

No-Show Policy: You are responsible for notifying us if you are unable to make your appointment. If your appointment is not cancelled at least **24 hours in advance** you will be charged a **$50 fee**. If your appointment is for a surgical procedure or Photodynamic Therapy (PDT) and is not cancelled at least **48 hours in advance** you will be charged a **$100 fee**. This fee will not be covered by your insurance company and must be paid in full before we allow you to schedule your next appointment. After three no-shows, a patient may be discharged from the practice.

Late Policy: If you arrive late for your appointment, our providers will need to continue seeing other patients who are on time. If you miss your entire appointment window, there is no guarantee that you will be seen. However, you will have the option to reschedule your appointment for a later date.

Non-Covered Services: An **Insurance Waiver** may be required to acknowledge understanding of your responsibility for **paying for non-covered services**. In dermatology, there are many procedures that are considered by Medicare and private insurers as **non-covered**, including removal of skin tags, cosmetic treatment of spider veins, removal of whiteheads, as well as others. If you are coming in for a non-covered service, please be prepared to pay for the service **in full**.

Return Check Fees: Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed a **$25.00 fee per check**.

Pathology Fees & Lab Tests: If your visit includes biopsies or lab tests these specimens are sent out for processing. You will receive separate billings from the laboratory performing the service. For service quotes or billing inquiries please contact your laboratory, we are unable to provide you with this information since they are a separate entity.

Hawaii General Excise Tax: The state of Hawaii imposes a General Excise Tax (4.712%) on all business activities, this will be assessed on all visit charges for PPO insurance plans and self-pay patients

ACKNOWLEDGEMENT OF RECEIPT

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice. Signing below signifies that you have had the opportunity to view the privacy notice by requesting a copy or reading a copy located on our website.

By signing below, you acknowledge you have read, understand, and agree to the Island Dermatology LLC's Patient Financial Policy and our Notice of Privacy Practices.

_____ _____

Patient Printed Name Patient Signature / Date

*The undersigned hereby provides consent as the **parent or guardian** of the above referenced minor patient.*

_____ _____ _____

Parent or Guardian Printed Name Parent or Guardian Signature / Date Relationship to Patient