Medical History

Patient's Last Name:	First:	Middle Initial:	DOB

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Anemia	COPD	Epilepsy	Thyroid Problems	Radiation Therapy
Anxiety	Coronary Artery Disease	Heartburn / Acid Reflux	Leukemia	Transplant of Bone Marr
Arthritis	Depression	Hearing Loss	Malignant Lymphoma	Other:
Asthma	Diabetes	HIV / AIDS	Malig Tumor of Lung	
Atrial Fibrillation	Disease Caused by COVID 19	Hypercholesterolemia	Malig Tumor of Breast	
BPH -Benign Prost Hyperplasia	High Blood Pressure	Hyperthyroidism	Malig Tumor of Colon	
Cerebrovascular Accident	End Stage Renal Disease: **Y or N**	Hypothyroidism	Malig Tumor of Prostate	

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Abdominal Resection	H/O Colostomy	Hysterectomy	Prostatectomy
Knee Joint Replacement Right / Left / Both	H/O Tubal Ligation	Kidney Biopsy	Prosthetic Arthroplasty Hips Right / Left / Both
Breast Biopsy	H/O Appendix	Low Anterior Resection of Rectum	Splenectomy
Biopsy of Prostate	**H/O Cholecystectomy – Gallbladder**	Lumpectomy of Breast Right / Left / Both	Skin Biopsy
Coronary Artery Bypass	H/O Colectomy	Mastectomy of Breast Right / Left / Both	Total Nephrectomy **- Kidney Removed**
Entire Kidney Transplant	H/O Liver Excision	Mech Heart Valve Replacement	Total Orchidectomy **-Testicle(s) Removed**
Exc of Basal Cell Carcinoma	H/O Coronary Angioplasty	Oophorectomy (Removal Ovaries)	Total Replacement Hip Joint Right / Left / Both
Excision of Melanoma	H/O Heart Valve Replacement	Pancreas (Pancreatectomy)	Transplant of Heart
Exc of Squamous Cell Carcinoma	H/O Total Cystectomy	Perc Extraction Kidney Stone	Transplant of Liver
	H/O Prostate	Portosystemic Shunt	Other:

SKIN CONDITIONS PAST AND PRESENT: (PLEASE CIRCLE ALL THAT APPLY)

Acne	Contact Derm – Poison Ivy	Melanoma	Sunburn
Actinic Keratosis	Dysplastic Nevus	Pruritus (Itching) of Scalp	Other:
Asteatosis Cutis – Dry Skin	Eczema	Psoriasis	
Basal Cell Carcinoma	H/O Hay Fever	Squamous Cell Carcinoma	

Do you wear sunscreen: ❑ Yes ❑ No Do you tan in a tanning salon: ❑ Yes ❑ No

LIST CURRENT MEDICATIONS: (CONTINUED ON BACK - MARK HERE ❑) NONE ❑

If you have a LIST, please give to front desk **Please contact your pharmacy and have them fax a list of your current meds if you don't have them with you. FAX: 7312868008 Medications**	**Strength**	**Frequency**	**Start Date**

Medical History

Patient's Last Name:	First:	Middle Initial:	DOB:

MEDICATIONS YOU ARE ALLERGIC TO & REACTION: ❑ NONE

❑ Penicillin	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Sulfa Drugs	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash ,Other:
❑ Erythromycins	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Tetracyclines	Anaphylaxis(Throat Swelling), Angioedema(Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Codeine	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Other:	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Other:	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:

SOCIAL HISTORY:

Do you smoke: ❑ Yes ❑ No Have you ever smoked: ❑ Yes ❑ No

In the past YEAR:
Do you drink: ❑ Yes ❑ No One drink per: _____ day / week / month / year

Do you exercise: ❑ Yes ❑ No Frequency: ❑ Daily ❑ Weekly ❑ Monthly

Do you drink caffeine ❑ Yes ❑ No Frequency: ❑ Daily ❑ Weekly ❑ Monthly ❑ Social

Last menstrual period: _____/_____/_____

Has your pcp / cardiologist told you to take antibiotics before surgery: ❑ Yes ❑ No

Occupation / Work Place:

What Pharmacy do you use: _____ Zip Code: _____

FAMILY HISTORY: (PLEASE CHECK ALL THAT APPLY)

	Mom	Dad	Sister	Brother
High Blood Pressure				
Heart Disease				
Thyroid Problems				
Diabetes				
Melanoma Skin Cancer				
Cancer:				
Other:				

PLEASE CIRCLE ALL THAT APPLY TODAY:

Epinephrine Hypersensitivity (Tachycardia)	Ear Pain	Heart Burn	Lidocaine Allergy
Sensitivity to Sunlight	Hoarseness	Hematochezia (Bloody Stool)	Defibrillator
History of Mucous Membrane Ulcerations	Nasal Congestion	Nausea	Pacemaker
Allergies (Nasal)	Nasal Discharge	Dysuria (Painful Urination)	Palpitations
Chills	Nose Bleeds	Hematuria (Bloody Urine)	Aspirin
Fever	Ringing in Ears	Headaches	Blood Thinners
Night Sweats	Sore Throat	Vertigo / Dizziness	Prolonged Bleeding
Unexplained Weight: LOSS / GAIN	Cough	Anxiety	Pre-op Antibiotics Recommended
Antibiotics Induce "YEAST" Infection	Shortness of Breath	Depression	Joint Swelling
Fatigue	Asthma / Wheezing	Pregnant / Planning Pregnancy	Joint Pain
Dysequilibrium	Antibiotics – GI Intolerance	Breastfeeding	Port-A-Cath

DYERSBURG SKIN & ALLERGY CLINIC

REGISTRATION FORM

(Please Print)

Today's date:	**Social Security #:**

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle Initial:**

Sex: ❑ M ❑ F	**Birth Date:**	**Age:**		**Marital status (circle one):** Single / Married / Div / Sep / Widow

Race / Ethnicity: ❑Caucasian / ❑African American / ❑Hispanic / Other:	**Language:** ❑English / ❑Spanish / Other:_____

Mailing Address:	**City:**	**State:**	**ZIP Code:**

Email Address:

Telephone #: ( )	**Cellular Telephone #:** ( )
Employer: ❑ **Unemployed** ❑ **Disabled** ❑ **Retired**	**Employer Telephone #:** ( )

Referred By: ❑ Dr. _____ ❑ Family ❑ Friend ❑ Spouse ❑Other: _____

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	**Relationship:** ❑ Spouse ❑ Child ❑ Friend ❑ Other:_____
Home Telephone #: ( )	**Cellular Telephone #:** ( )

INSURANCE INFORMATION

Primary Insurance: BCBS / Medicare / UHC / Cigna / UMR / Blue Care / Aetna / Other:	**Identification #:**	**Group #:**
Secondary Insurance: BCBS / Medicare / UHC / Cigna / UMR / Blue Care / Aetna / Other:	**Identification #:**	**Group #:**

Assignment of Benefits & Release Form

MY SIGNATURE AND DATE, ON THE LINE BELOW, AUTHORIZES EACH OF THE FOLLOWING:

1. Assignment of all Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Dr. Busch, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

2. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Busch for any services provided to me by the physician. I authorize the release of any necessary information to the Health Care Financing Administration to determine the benefits available for the service provided by my physician. I understand that by signing below, I am giving my physician / staff permission to request and collect payment. In addition, I am aware and authorize my physician to submit the medical and personal information necessary to collect payment. If other health insurance is indicated in item 9 of HCFA – 1500 Form, elsewhere on the other approved claim forms, or on electronically submitted claims, my signature authorizes release of the information to my insurer / agency. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

3. I authorize treatment and agree to pay any and all fees and charges for such treatment. I agree to pay all charges for members of my family shown by statements, promptly upon presentation. If your claim is not paid within 90 days, you will be expected to pay the balance for the date of visit concerned. If any incorrect information is given to us and your claim is denied, you will be expected to make full payment. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family, I agree to pay reasonable attorney's fee or other such cost as the Court determines proper.

_____ _____

Signature of Patient / Insured / Guardian Date

Dyersburg Skin & Allergy Clinic, 1950 Cook Street, Ste, B, 710 Hwy 51 ByPass, Dyersburg, TN, 38024

Acknowledgement of Privacy Practices & Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use and disclosure of their personal health information. Our Notice of Privacy Practices has been provided to you today. The patient understands that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) that:

- Protected health information may be used and disclosed to provide and coordinate treatment among a number of health care providers who may be involved in that treatment directly and indirectly, payment with your insurance company, or healthcare operations within our office.
- Dyersburg Skin & Allergy Clinic has a Notice of Privacy Practices that is available for review.
- The patient has the right to restrict the use of their information, but Dyersburg Skin & Allergy Clinic does not have to agree to these restrictions, if, for example, it interferes with payment, daily operations, or providing quality care. If we do agree, then we are bound to abide by such restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- Dyersburg Skin & Allergy may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service).

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, are as follows:

- The patient has the right to be notified of a protected health information breach.
- The patient has the right to ask for a copy of their electronic health record in electronic form.
- Dyersburg Skin & Allergy Clinic cannot sell a patient's health information without their permission.
- Certain uses of a patient's medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practices will only be made with a patient's authorization.

My signature confirms that I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses of disclosures of my protected health information. I have been offered a copy and therefore have been given the right to review such Notice of Privacy Practices; however, it is also available for review at the front desk and on our company website, www.dyersburgskinandallergyclinic.com.

_____ _____

Signature of patient / Insured / Guardian Date