



DERMATOLOGY BY SHELLY

NAME: _____ TODAY'S DATE _____/_____/_____

HOW DID YOU HEAR ABOUT US? _____

DOB: _____/_____/_____ SEX: MALE____ FEMALE____ NON-BINARY____

RACE: AMERICAN INDIAN__ BLACK__ WHITE__ ASIAN__ HISPANIC/LATINO__
OTHER _____

MARITAL STATUS: Married____ Single____ Divorced____ Widowed____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SECONDARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ RETIRED: _____

WORK PHONE: _____ NOT EMPLOYED _____

SOCIAL SECURITY # _____ (REQUIRED FOR MEDICARE)

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____

IS THERE ANYONE WE ARE ABLE TO SHARE YOUR HEALTH INFORMATION WITH:

NAME: _____ RELATIONSHIP: _____

PHONE # _____

All Information can be shared _____ Only The Information Stated Below May Be Shared

NAME: _____ DOB: _____ / _____ / _____

MEDICAL INFORMATION

Please give insurance cards, guarantor information and driver's license to the front staff if not already done so.

SELF PAY/ NO INSURANCE: _____

Primary Insurance: _____ Secondary Insurance: _____

Please give cards and proper identification to the front desk if you have not done so already

Primary Care Provider _____ Name of Practice _____

Phone # _____

Referring Provider (If different) _____ Name of Practice _____

Phone # _____

PREFERRED PHARMACY NAME & STREET _____

REASON FOR VISIT TODAY: _____

FYI: IF YOU ARE HERE FOR SKIN CHECK, HAIR LOSS OR RASH YOU MAY NEED TWO SEPARATE APPOINTMENTS AS SOMETIMES THESE VISITS CAN TAKE QUITE SOME TIME. YOUR PROVIDER WILL DO THEIR BEST TO ACCOMODATE YOU.

MEDICATION ALLERGIES OR SENSITIVITIES AND THE REACTION: NONE _____

1) _____ / _____ 2) _____ / _____

3) _____ / _____ 4) _____ / _____

5) _____ / _____ 6) _____ / _____

MEDICATIONS:

Do you consent to Dermatology & Skin Care by Shelly transferring medication from the pharmacy database, if available?

Yes _____ No _____

We ask that you provide a list of medications on the following page for our review. If you have a list that you carry, we would be happy to take a copy with your consent.

NAME: _____ DOB: _____ / _____ / _____

MEDICATIONS (Including Vitamins and Supplements)

Please list or provide a list of all medications. Please understand that certain medications may be contraindications to specific treatments or procedures. We rely on the accuracy of the information you provide to deliver safe and effective care.

NONE _____

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

NAME: _____ DOB: _____ / _____ / _____

HISTORY OF SKIN CANCER

- ☐ BCC
- ☐ SCC
- ☐ MELANOMA
- ☐ MERKEL CELL
- ☐ FAMILY HISTORY OF MELANOMA
- ☐ OTHER _____

Do you wear sunscreen/sunblock? Yes ____ No ____

PLEASE CHECK ANY HISTORY OF THE FOLLOWING
(If you check any of the boxes with a star please explain on lines below)

- | | | |
|---|---|--|
| ☐ Anxiety | ☐ Kidney Disease | ☐ Sjogrens' |
| ☐ Asthma | ☐ Gerd | ☐ Other AutoImmune Disease* |
| ☐ A-Fib | ☐ Hearing or vision impairment | ☐ Pacemaker |
| ☐ SVT | ☐ HIV/AIDS | ☐ Internal Defibrillator |
| ☐ Heart Attack | ☐ Hepatitis B or C | ☐ Artificial Joints* |
| ☐ Stroke | ☐ Fatty Liver | ☐ MRSA |
| ☐ HighBlood Pressure | ☐ Liver DZ* | ☐ Organ Transplant* |
| ☐ Enlarged Prostate | ☐ Thyroid Disease* | ☐ Diabetes |
| ☐ Depression | ☐ Leukemia* | ☐ Psoriasis |
| ☐ Needle Phobia | ☐ Lymphoma* | ☐ Cancer* |
-
-
-
-

☐ **Neurological Disorders (please Circle or list if not an option)**
(Alzheimer's, Amyotrophic Lateral Sclerosis (ALS), Brain Tumors, Epilepsy, Seizures, Cerebral Aneurysm, Bell's Palsy etc.) _____

☐ **Musculoskeletal Disorders (please Circle or list if not an option)**
(Osteoarthritis, Rheumatoid arthritis, Gout, Osteopenia, Spondyloarthritis, Sarcopenia, etc.) _____

☐ **Autoimmune Disorder (please Circle or list if not an option)**
(IBD, RA, Lupus, Type 1 Diabetes, MS, Scleroderma, Psoriasis, Psoriatic Arthritis, Guillain-Barre Syndrome, Chronic Inflammatory Demyelinating Polyneuropathy, Myasthenia Gravis, Thyroid Dz, Vasculitis etc.) _____

OTHER: _____

NAME: _____ **DOB:** _____ / _____ / _____

PLEASE CIRCLE THE ANSWER THE FOLLOWING QUESTIONS:

What is your smoking status? Current | Former | Never

If you are a current smoker, how many packs a day do you smoke? _____

Do you consume alcohol? Yes | No |

If yes, how much? Less than 1 drink / day | 1-2 drinks / day | 3 or more drinks / day |

For Patients 66 and Older:

Have you received the pneumonia vaccine? Yes | No |

Do you have a healthcare proxy in the event you cannot make your own medical decisions? Yes | No |

Do you have a living will? Yes | No |

PLEASE REVIEW AND SIGN CONSENT FORMS FOLLOWING THIS PAGE

NAME: _____ **DOB:** _____ / _____ / _____

AUTHORIZATION TO PROVIDE CARE/INSURANCE PAYMENTS

I hereby give consent to DERMATOLOGY & SKIN CARE BY SHELLY to provide whatever treatment they may deem necessary to the patient above. The insured party must sign for all claims. Dependent patients must sign, if not a minor. I authorize insurance companies, organizations, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to my claim. I certify that the information I provided to be true and correct. I know it is a crime to fill out this form with facts I know to be false or omit facts that are important. I assign payment directly to providers of Dermatology & Skin Care by Shelly which may be due from Medicare or any other insurance company. I understand I am financially responsible to pay Dermatology & Skin Care by Shelly for any non-covered insurance services.

Signature: _____ **Date:** _____ **Patient Name (Please Print)** _____

GENERAL CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent to care, treatment, testing and all other services performed by healthcare providers at Dermatology & Skin Care by Shelly. I understand that I have the right to refuse to consent to any proposed care, testing, surgeries or procedures. I also understand that I have the right to ask questions and discuss my concerns with my healthcare provider. I am aware that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees will be made to me as to the outcome of my care, examination, and/or treatment from Dermatology & Skin Care by Shelly. I understand that imagery and photography may be used in the course of my visits in order to protect and authenticate my medical identity. I understand that I am required to sign this consent annually or whenever the office deems it necessary. I understand that I may revoke this consent at any time by writing to Dermatology & Skin Care by Shelly at 1598 Susan A Williams Way, Suite E, Chino Valley, AZ 86323. By signing this form, I agree that I have read and fully understand the content and references contained above in this general consent form in its entirety. I acknowledge that all of my questions have been answered to my personal satisfaction.

Signature: _____

Print Name: _____ **Date:** _____

NAME: _____ DOB: _____ / _____ / _____

RECEIPT/REVIEW OF HIPAA PRIVACY PRACTICES

I understand that as part of my health care, Dermatology & Skin Care by Shelly originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have reviewed and understand that Dermatology & Skin Care by Shelly *Notice of Privacy Practices* provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Dermatology & Skin Care by Shelly's Notice of Privacy Practices prior to signing this acknowledgement; I understand that Dermatology & Skin Care by Shelly reserves the right to change their Notice of Privacy Practices, and prior to any implementation of this, will mail a copy of any revised notice to the address I've provided, if requested.

Patient or Authorized Representative's Signature

Date ____ / ____ / ____

Printed Name

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

Individual refused to sign

Communication barrier prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (please specify)

Date _____ Signature of Witness