MEDICAL HISTORY & INTAKE FORM (2025 - 2026)

Patient Name	Date of Birth	Phone Number
Patient Address		
Email Address/Patient Portal Access:		

- ☐ As a patient of this practice, I do **NOT** permit MD Dermatology to disclose any information regarding my health care or treatment to anyone without written permission or legal authorization.
- ☐ As a patient of this practice, **I DO** permit MD Dermatology to disclose any information regarding my healthcare or treatment to:_____

Pharmacy Name	**Pharmacy Phone Number**	**Pharmacy Location** (City)

MEDICAL HISTORY (mark all that apply)

Anxiety	Diabetes	Radiation Treatment
Arthritis	End State Renal (Kidney Disease)	Stroke
Asthma	GERD	Seizures
Atrial Fibrillation	Hearing Loss	None
Bone Marrow Transplant	Hepatitis/Liver Disease	
Enlarged Prostate	High Blood Pressure	Other:_____
Cancer:(type)_____	HIV - AIDS	_____
COPD	High Cholesterol	_____
Coronary Artery Disease	Hyperthyroidism	_____
Depression	Hypothyroidism	

SURGICAL HISTORY (mark all that apply)

Appendectomy	Joint Replacement Knee (L - R)	Prostate Biopsy
Bladder Surgery	Kidney Biopsy	TURP (Prostate)
Breast Biopsy	Kidney Stone Removal	Lower Anterior Resection
Breast Lumpectomy	Nephrectomy	Melanoma
Mastectomy (L - R)	Hepatectomy	Splenectomy
Hysterectomy	Endometriosis Oophorectomy	Orchiectomy
Diverticulitis	Ovarian Cystectomy	Fibroidectomy (Uterus)
Inflammatory Bowel Disease	Ovarian Cancer Oophorectomy	Other:_____
Colostomy Bag (Colon)	Valve Replacement (Heart)	_____
Cholecystectomy (Gallbladder)	Transplant:_____	
Artery Bypass of Heart	Pancreatectomy (Pancreas)	
Joint Replacement Hip (L - R)	Angioplasty	

SKIN DISEASE HISTORY (mark all that apply)		
Acne	Precancerous Moles	Basal Cell Carcinoma
Poison Ivy	Eczema	Actinic Keratosis
Psoriasis	Flaking/Itchy Scalp	Other:_____
Hay Fever	Allergies	_____
Melanoma	Dry Skin	_____
Squamous Cell Carcinoma	Blistering Sunburns	

Do you wear sunscreen: [ ] YES [ ] NO
SPF:_____

Tanning Salon History: [ ] YES [ ] NO

VITALS (pediatric patients only)

Height: _____ ' _____ "

Weight: _____ lbs.

MEDICATIONS

_____
_____
_____
_____
_____
_____

Medication Allergies:

_____
_____

Social History:

[ ] Never Smoked [ ] Former Smoker [ ] Current Someday Smoker [ ] Current Smoker

Alcohol Status:

[ ] None [ ] Less Than 1 Drink [ ] 1-2 Drinks Daily [ ] 3+ Drinks Daily

VACCINES

Did you receive your flu vaccine this year? [ ] YES [ ] NO
Have you received the pneumonia vaccine? [ ] YES [ ] NO

Has the patient had a meningococcal vaccine (serogroups A,C,W,Y) **on or between their 11th and 13th birthdays?** [ ] YES [ ] NO

Has the patient had tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) **on or between their 10th and 13th birthdays?** [ ] YES [ ] NO

Has the patient had at least two HPV vaccines (with at least 146 days between the two) **OR three HPV vaccines on or between the patients 9th and 13th birthdays.** [ ] YES [ ] NO

Did the patient not receive any of the vaccinations above because of a medical reason, including allergic reactions? [ ] YES [ ] NO

REVIEW OF SYSTEMS			
Problems with healing:	YES – NO	Problems with Bleeding	YES – NO
Problems with scarring:	YES – NO	Pacemaker/Defibrillator	YES – NO
Blood Thinners:	YES – NO	Artificial Joints	YES – NO
Artificial Heart Valve:	YES – NO	Immunocompromised	YES – NO
History of MRSA:	YES – NO	Allergy/Sensitivity Adhesive	YES – NO
Allergy/Sensitivity Lidocaine	YES – NO	Antibiotics Prior to Surgery	YES – NO

PLEASE FILL OUT IF OVER THE AGE OF 65 YEARS OLD:

Do you have a health care proxy to assist in making medical decisions on your behalf?

[ ] YES [ ] NO

Health Care Proxy Name:_____

Contact Phone Number:_____

Relationship to Patient:_____

Do you have a living will or an advanced directive? [ ] YES [ ] NO

Please choose which statement(s) applies to your wishes regarding the advanced directive:

- ☐ Do **NOT** Resuscitate (no CPR or defibrillator)
- ☐ Do **NOT** Intubate (no breathing tubes)
- ☐ Intubate (breathing tubes)
- ☐ Full Cardiopulmonary Resuscitation (CPR/defibrillator)

FINANCIAL AGREEMENT OF OFFICE POLICES

I (the patient) consent to the use and disclosure of my protected health information (PHI) for the treatment, payment, operations, and such other purposes that are permitted under the Federal Health Insurance Portability and Accountability Act without written authorization.

I accept that I am financially responsible for all services rendered on my behalf by Sanjiv K. Saini, MD / MD Dermatology & Laser Center. For those insurance plans for which the practice accepts my assignments, I accept personal responsibility for all copayments, deductibles, and non-covered services, as dictated by my insurance coverage/plan. This constitutes a formal consent & wavier to obtain medical services in the event my insurance plan requires a referral and I have not obtained one.

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, or their designated representatives, to charge 40% additional amount that may be incurred in the collection of any unpaid debts. I understand that I am liable for these charges should I become delinquent in my payments to the practice.

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When you are scheduled for an appointment we have set aside time to address your questions and concerns. Therefore, it is essential that all patients arrive at their scheduled time. Should you arrive **15 minutes late** for your scheduled appointment time, you may/will be asked to reschedule your appointment.

Our office has a cancellation policy. At least 24 hours notice is required when canceling your appointment. A $50.00 fee will be charged to your account if proper notification is not given.

For surgeries, 3 business days notice is required when canceling the appointment. A $100.00 fee will be assessed if proper notification is not received.

Please sign below confirming that you have read, understand, and accept these office policies.

_____ _____

Patient/Legal Guardian Signature **Date**

_____

Patient Printed Name

_____

Patient Date of Birth

PATIENT CONSENT FOR USE DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Sanjiv K. Saini, MD/MD Dermatology & Laser Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. Please refer to Sanjiv K. Saini, MD notice of privacy practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sanjiv K. Saini, MD/MD Dermatology & Laser Center reserves the right to revise its notices at anytime. A Notice of Privacy Practices may be obtained by forwarding a written request to Sanjiv K. Saini (Privacy Officer) at:

3168 Braverton Street - Suite 340
Edgewater, MD 21037

With my consent, Sanjiv K. Saini, MD/MD Dermatology & Laser Center staff may call my home or other designated locations and leave a message on a voicemail in reference to any items that assist the practice in carrying out TPO (treatment, payment, operations.) such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

I promise to follow medical recommendations made by the doctor/provider and the staff who treat me. In the event I do not follow up with the recommended treatment plan, I fully accept the consequences of my failure to do so and fully release all providers and staff/organization associated with my care from all present and future liability.

By signing this form, I am consenting to Sanjiv K. Saini MD/MD Dermatology & Laser Center's use and disclosure of PHI to carry out TPO.

If I do not sign this consent, Sanjiv K. Saini MD/MD Dermatology & Laser Center may decline to provide treatment to me.

_____ _____

Patient/Legal Guardian Signature **Date**

_____

Patient Printed Name

_____

Patient Date of Birth

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used, disclosed and how to access this information. MD Dermatology & Laser Center is required by law to keep your information secure and confidential. Also, we need to give you this notice and the following terms outlined below:

- The law permits us to use or disclose your health information to those involved in your treatment including your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our EMR/Computer system.
- We may share your medical information with our business associates, such as billing services. We have a written contract with all business associates that requires them to protect your privacy.
- We may use your information to contact you, for example, we may send newsletters or other information to you. We may also call and remind you about the appointments, if you are not home we may leave this information on your answering machine or with the person that answers your phone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We will need to release some or all of your health information when required by law.
- If this practice is sold, your information will become property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization. This includes use in marketing.
- You may request in writing that we not use your protected health information beyond above normal uses.
- You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communications, number or method.
- You have the right to see and receive a copy of your health information with a few exceptions, Give us a written request regarding the information you want to see. If you want a copy of your records we may charge you a reasonable fee for copies, If you would like a digital copy for your records, we will try to accommodate your request.
- You have the right to receive a report of who we disclose your information to.
- If our privacy and security measures/systems are breached in any way we will notify you.
- You have the right to receive a copy of this notice.
- If we change any of the details in this notice we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services in writing at:
  200 Independence Ave, SW Room 509F, Washington DC 20201
  Online: www.hhs.gov
- You will not be retaliated against for filing a complaint.
- Please contact our office administrator for any questions at (410) - 956 - 7777 to discuss the above information or file a complaint or assistance in contracting the Department of Health and Human Services.

Acknowledgement, I have read and have been offered a copy of these privacy practices and understand and agree to the information provided above.

_____ _____

Patient Signature **Date**