NAME: ____ **DATE OF BIRTH:** ____________________

Past Medical History: (please check all that apply…or check NONE)

_____Anxiety
_____Arthritis
_____Asthma
_____Atrial fibrillation
_____BPH (enlarged prostate)
_____Bone marrow transplant
_____Breast cancer
_____Colon cancer
_____COPD/Emphysema
_____Coronary artery (heart) disease
_____Depression
_____Diabetes
_____End stage kidney disease
_____GERD (acid reflux)
_____Hearing loss
_____Hepatitis
_____High cholesterol
_____HIV/AIDS
_____Hypertension – high blood pressure
_____Hyperthyroidism
_____Hypothyroidism
_____Leukemia
_____Lung cancer
_____Lymphoma
_____Prostate cancer
_____Radiation treatment
_____Seizures
_____Stroke
_____NONE of the above

Other Medical History:
____

Surgical History – over the past 1 year only

____

____

Skin Cancer History: (please check all that apply…or check NONE)

_____Actinic keratosis (pre-cancers)
_____Basal cell skin cancer
_____Melanoma
_____Squamous cell skin cancer
_____NONE

Other Skin Disease: ____

Do you wear sunscreen? _____Yes _____No
Do you use a tanning bed? _____Yes _____No
Family history of melanoma? _____Yes _____No

If yes, which relative(s): ____

Family history of non-melanoma skin cancer (basal cell carcinoma or squamous cell carcinoma)? _____Yes _____No

If yes, which relative(s): ____

Medications: (please list all current medications…or check NONE) _____ NONE

____

____

____

____

Allergies: (please list all medication allergies…or check NONE) _____ NONE

____

____

NAME: ____ **DATE OF BIRTH:** ____________________

Social History: (please check one in each category)

Alcohol Use:	Smoking:
_____None	_____Never smoked
_____Less than 1 drink per day	_____Quit – former smoker
_____1-2 drinks per day	_____Still smoke daily
_____More than 3 drinks per day	_____Still smoke less than daily

List your occupation or retired or student: ____

Race:	Preferred Language:	Ethnicity:
_____White	_____English	_____Hispanic/Latino
_____Am Indian/Alaska Native	_____Spanish	_____Non-Hispanic/Other
_____Asian	_____Decline to Specify	_____Decline to Specify
_____Black/African American	Other_______________	
_____Decline to Specify		

Pharmacy: Name and Location with Zip Code:____

Primary Care Physician: ____

Review of Systems: (please check yes or no in response to each)

Fever or chills	_____ Yes	_____No
Cold or flu or sore throat	_____ Yes	_____No
Chest pain	_____ Yes	_____No
Breathing problems – shortness of breath, cough	_____ Yes	_____No
Stomach problems – nausea, vomiting, diarrhea	_____ Yes	_____No
Any healing, scarring, or bleeding concerns	_____ Yes	_____No

Medical Alerts: (please check yes or no in response to each)

Allergy to adhesives	_____ Yes	_____No	Need antibiotic prior to surgery	_____ Yes	_____No
Allergy to lidocaine	_____ Yes	_____No	Allergy to topical antibiotics	_____ Yes	_____No
Blood thinners	_____ Yes	_____No	Pacemaker or defibrillator	_____ Yes	_____No

Chief Complaint: Give the primary reason you are here today. **Please prioritize and list no more than two complaints**. To respect other patient appointment times, a second visit will need to be made to address any additional concerns.

____

____

____

____

____________________________________ ____________________________

Patient or Guardian Signature Date

____________________________________ ____________________________

Physician Assistant Signature Date

____________________________________ ____________________________

Dermatologist Signature Date

PATIENT: ____

DATE OF BIRTH: ____

EMAIL:____ *(For Patient Portal Access and Appt Reminders only)*

IMPORTANT PLEASE READ - Office Policies and Permission to Bill Insurance

- I authorize O'Fallon Dermatology Specialists to release to Medicare or my insurance carrier any information needed to process my insurance claims. I permit this authorized information to be used to request payment to O'Fallon Dermatology Specialists.
- I understand that I must present a valid driver's license and a current insurance card at every office visit. I agree that all co-pays and prior account balances will be paid prior to seeing the providers. I understand that there is a $30 fee for returned checks.
- I understand that it is my responsibility to provide valid up-to-date insurance cards, both primary and secondary. I am aware that O'Fallon Dermatology Specialists will bill my insurance company(s) based on the cards and information that I provide. I know that if I provide incorrect insurance information or invalid insurance card(s) that result in my claim being denied, I will be responsible for payment of all charges denied by my insurance company. I understand that once I have paid these charges, I may personally submit a corrected insurance claim to my insurance carrier(s) in order to receive personal reimbursement. I agree that it is not O'Fallon Dermatology Specialists responsibility to correct my mistake. I understand that I may ask O'Fallon Dermatology Specialists to resubmit a corrected claim (one time only) with the correct cards and information that I provide after an initial denial. I have been informed that there will be times when O'Fallon Dermatology Specialists cannot resubmit a corrected claim based on my insurance carrier's timely filing requirements.
- Once my insurance company has paid its portion of the office charges, I am aware that I will receive a statement for any charges that my insurance has determined are my responsibility. I understand that payment for these charges is due in full at the time I receive the first statement and that I will be charged a $10 late fee every month for any charges that are not paid before the next billing statement. I know that O'Fallon Dermatology Specialists will not provide me with a payment plan but that the company does accept most major credit cards. I have been informed that if I fail to pay my account balance in a timely manner that I may be discharged from the practice for non-payment.
- I agree that I will give 24 hours advance notice of an appointment cancellation and I understand that I will be charged a $50.00 no-show fee if I fail to provide this notice.
- I understand that my provider may access my current medications from my pharmacy in order to ensure that my medications are up to date. I also agree that my provider may use a recording device or a scribe during my office visit to assist with documentation.

Consent to Use and Disclose Medical Information (HIPAA)

I understand that as part of my healthcare, O'Fallon Dermatology Specialists creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the health professionals who care for me, a source of information for applying my diagnosis and treatment information to my bill, and a means by which my bills can be submitted to and paid by a third party payer. I know that O'Fallon Dermatology Specialists has a published *Privacy Practices Policy* that provides a more complete description of information uses and disclosures. I have the right to review the full policy prior to signing this consent. I have the right to request restrictions as to how my health information may be used or disclosed and to whom it may be disclosed, other than for purposes of communication among health professionals and submission and payment from third party payers. I agree to allow my care provider to access my pharmacy medication records electronically as needed to manage my health care.

I agree that O'Fallon Dermatology Specialists may use the following forms of communication to relay a message to me regarding my medical information: telephone messages at the phone number(s) provided, written communication to the address provided, and email messages to the email address provided. I also authorize my health care provider to employ a third-party automated outreach & messaging system to use to the contact information that I provided for appointment reminder messaging.

I give Dr. Angela Spray and the staff of O'Fallon Dermatology Specialists permission to discuss my medical information with the following people: (Please list names, phone numbers, and relationships)

____

____

Signature of Patient or Legal Representative/Custodian

Signature:____ Date: __________________________