Arlington Dermatology

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PATIENT INFORMATION

Date: _________________________

Patient Name: ____ **Date of Birth**: _________________________
(LAST) (FIRST) (M.I.)

Address: ____ **Apt/Unit#:** ___________________________

City: ____ **State:** _____ **Zip Code:** ______________

SSN #: _______ - _______ - ____________ **Gender:** ☐Male ☐Female ☐Other

Home Phone #: ( ) __________________ **Cell Phone #:** ( ) ________________

Email: _____________________________________ **Preferred Method of Contact:** ☐Home Phone ☐Cell Phone ☐Email

Marital Status: ☐ Single ☐Married ☐Divorced ☐ Separated ☐ Widowed

Race: ☐American Indian ☐Asian ☐ Black or African American ☐Native Hawaiian ☐White ☐Other__________

Ethnicity: ☐Hispanic ☐ Non-Hispanic ☐Unknown **Preferred Language:** _______________________

Employer Name: ______________________________ **Occupation:** ______________________________

Name of physician who referred you to our practice: ____

PATIENTS UNDER 18 YEARS OF AGE:

Name of Responsible Party: ____
(LAST) (FIRST) (M.I.)

Relationship to Patient: ______________________ **Responsible Party Phone:** ( ) ___________________________

Responsible Party Address/Apt # (if different than above): ____

City: _______________________ **State:** ____ **Zip Code:** _______ **Responsible Party Date of Birth:** _______________

PRIMARY INSURANCE INFORMATION *(In order for us to file a claim on your behalf, this section must be completed by the patient.)*

Primary Insurance Name: ____

ID#: ____ **Group/Policy #:** ____________________________

Subscriber Name: _____________________________________ **Subscriber's Date of Birth:** ___________________

Relationship to Patient: ________________________________ **Subscriber's SSN #:** ________ - _____ - _________

HMO Primary Care Doctor (if applicable): ____

SECONDARY INSURANCE INFORMATION *(In order for us to file a claim on your behalf, this section must be completed, if applicable.)*

Primary Insurance Name: ____

ID#: ____ **Group/Policy #:** ____________________________

Subscriber Name: _____________________________________ **Subscriber's Date of Birth:** ___________________

Relationship to Patient: ________________________________ **Subscriber's SSN #:** ________ - _____ - _________

Acknowledgement of HIPAA/Receipt of Information Practices Notice

I understand that as part of my healthcare, this facility 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 been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that the above listed information may be used to:

- Conduct, plan, and direct my treatment and follow up care among multiple healthcare providers, as applicable
- Obtain payment from 3rd party payers
- Conduct normal healthcare operations such as quality assessment and physician certifications

I understand that I may request in writing to have the use or disclosure of my private information restricted in regards to treatment, payment, and healthcare operations. I also understand that Arlington Dermatology is not required to agree to my requested restrictions. In the case that Arlington Dermatology does agree to any restrictions requested, we are bound to abide by them as stated by you.

Contact Permission

In the event that you are contacted regarding an appointment, lab results, medication, or any other reason, you permit Arlington Dermatology to discuss confidential information with:

Please check all that apply:

- ☐ Speak only with patient
- ☐ Leave a message on an answering machine
- ☐ Speak with spouse/ significant other; Name: ____________________________________
- ☐ Speak with other family members; Name(s): ____________________________________

Cancellation/No Show Policy

If the patient cannot attend a scheduled appointment, it is the patient's responsibility or responsible party to call the office to cancel at least 24 hours prior to scheduled appointment.

PLEASE NOTE: Arlington Dermatology reserves the right to charge $25 fee if the patient does not cancel their appointment within 24 hours. Patients scheduled for surgery or cosmetic procedures will be assessed a $50 cancellation fee for no shows.

Product Return Policy

All product sales are final. Products are non-returnable, non-refundable, and non-exchangeable except under specific medical circumstances. For full policy information, please see the front desk.

Authorization/Assignment/ Financial Responsibility

By signing below, I certify that I, or my dependent, have benefits issued by the above listed insurance plan(s) as completed by me, and hereby assign directly to ARLINGTON DERMATOLOGY any benefit for services rendered. I authorize the release of information when necessary to secure the payment of such benefits to ARLINGTON DERMATOLOGY. I authorize the use of the signature below on all insurance submissions as required. I fully understand that I am responsible for any and all charges associated with services rendered and agree to pay for costs not covered by my insurance, as per my individual contract with my insurance company. I understand that ARLINGTON DERMATOLOGY will attempt to recover any unpaid balance and may refer my account to a collection agency for any outstanding balance due.

My signature below indicates that I have read and understood the above statements and agreed upon them.

Patient Name: ____

Patient Signature (or Responsible Party): ____ **Date:** _____ /_____ /_____

Relationship to patient: ____

GENERAL HEALTH HISTORY

Patient Name: ________________________________ **DOB:** _______________ **Date:** ___________________

Social History:

Tobacco Use: ☐ Never ☐ Current everyday; Date Started: ___________ ☐ Former; Date Quit: ___________

Alcohol Use: ☐ Never ☐ < 1 per day ☐ 1-2 per day ☐ 3 or more per day

Family Medical History:

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative (s)? ____

Any other family history: ____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? ___________

Do you tan in a tanning salon? ☐ Yes ☐ No

Female patients:

Are you currently pregnant? ☐ Yes ☐ No If yes, Are you breastfeeding? ☐ Yes ☐ No

Are you using contraceptives? ☐ Yes ☐ No Are you currently trying to conceive? ☐ Yes ☐ No

Patients 65 years of age and older:

Have you received a pneumonia vaccine? ☐ Yes ☐ No

Do you have a health proxy (POA) in the event you are unable to make your own decisions? ☐ Yes ☐ No

If yes, please list Designee name and phone number: ____

Do you have a living will? ☐ Yes ☐ No

Which of the following statements best reflects your wishes on advanced care recommendations?

- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Medication History:

(Please list all current medications and over-the-counter drugs. Please specify what conditions they are used for.)

______ **Initial here if you release us to obtain your medication list directly from your pharmacy via electronic download**

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Preferred Pharmacy Name: ________________________________ **Pharmacy Phone #:**(   ) ______________________

Pharmacy Address: ____

Allergies:____

Arlington Dermatology

PERSONAL HEALTH HISTORY

Name:___________________________________ **Date:**___________________

Past Medical History: (please circle all that apply) ☐ None

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension/High Blood Pressure
HIV/AIDS
Hypercholesterolemia/High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
Other: _____________________________

Past Surgical History: (please circle all that apply) ☐ None

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Other: _____________________________

Skin Disease History: (please circle all that apply) ☐ None

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other: _____________________________