PATIENT INFORMATION (PLEASE PRINT)

First Name_____ Middle Initial _____ Last Name_____

Date of Birth _____/_____/_____ Social Sec. # _____-_____ Sex: ☐ M ☐ F

Language: ☐ English ☐ Spanish ☐ Other:_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Native American ☐ Pacific Islands ☐ Other _____

Home Phone_____ Cell Phone _____

Preferred Phone: ☐ Home ☐Cell E-mail Address_____

Home Address_____ City_____ State _____ Zip _____

Primary Care: _____ Referring Physician: _____

Emergency Contact_____ Relationship _____ Phone_____

PHARMACY INFORMATION

Pharmacy Name:_____ Phone Number:_____

Pharmacy Location(street name and/or zipcode): _____

RESPONSIBLE PARTY

If same as above check here: ☐

Person Responsible:_____ Relationship_____

Billing Address:_____ City:_____

State:_____ Zip:_____ Phone #:_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK-IN)

Primary Insurance _____ Policy I.D._____

Effective Date: _____ Group # _____ Co-pay amount _____

Subscriber Name_____ DOB _____

Patient Relation to Policy Holder: ☐Self ☐ Spouse ☐ Child ☐_____

Secondary Insurance _____ Policy I.D._____

Effective Date: _____ Group # _____ Co-pay amount _____

Subscriber Name_____ DOB _____

Patient Relation to Policy Holder: ☐Self ☐ Spouse ☐ Child ☐_____

PATIENT PORTAL

☐ Yes! I would like to enroll in Patient Portal - Sign up for Portal Access and you will have the ability to:
✓ Receive test results ✓ Request prescription refill ✓ Contact our appointment staff ✓ Contact procedure coordinators
For any non-urgent questions regarding your health care, medications, appointments, and insurance issues, send us an e-mail and we will respond promptly. For all urgent matters, please call the office directly. If you check yes above, you will receive an e-mail from our office. Within that e-mail, there will be a link that will enable you to connect to the portal in order to complete your registration. If you do not receive any message, please be certain to check your spam folder and your spam settings.

Financial Policy

Payment is required at the time services are rendered unless you are covered by an insurance company with which DermCARE Practitioners participates. We accept payment in the form of cash, check, or credit/debit card. I understand that it is my responsibility to present accurate, current insurance coverage information at the time of check-in. I will be asked to pay for all services not covered, deductible amounts, co-pays, past due balances, as well as balances due resulting from invalid insurance information.

I understand that it is my responsibility to cancel my appointment with DermCARE Practitioners 24 hours prior to the appointment date and time or I may be billed $25 for the missed appointment.

IF A REFERAL IS REQUIRED, I will be held responsible to obtain and present this referral prior to my visit. If this is not provided at the time of my visit, services provided will remain my responsibility.

I**,** as the patient or responsible party for the patient, agree to be responsible for charges or services referred to another health care provider or laboratory by any health care provider of DermCARE Practitioners.

I understand it is the policy of DermCARE Practitioners to collect any outstanding balance before additional services are rendered.

Consent for Treatment

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my health care provider. Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with treatment, it is my responsibility to request a procedure estimate prior to starting treatment. **COSMETIC PROCEDURES AND OTHER MEDICALLY UNNECESSARY SERVICES WILL NOT BE BILLED TO YOUR INSURANCE AND ARE THE PATIENT'S RESPONSIBILITY FOR PAYMENT IN FULL AT TIME OF SERVICE**.

Minor Patients

All minor patients (less than 18 years of age) must be accompanied by their parent, grandparent, or legal guardian on their first visit. If under the age of 16, the patient may only be seen with a parent, legal guardian, or grandparent present.

Communication

In DermCARE Practitioners discretion, a confidential message may be left on your voicemail or answering machine at the preferred number(s) indicated below. Such message may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff.

Preferred Number: _____ ☐ Mobile (cell) ☐ Work ☐ Home

Preferred Number: _____ ☐ Mobile (cell) ☐ Work ☐ Home

Preferred Email Address:_____

DermCARE Practitioners may also communicate with you via e-mail, text message, or by phone provided such method complies with applicable HIPAA communication standards. Unless you check below, you specifically authorize and give your consent to receive autodialed or pre-recorded calls including, voice and short message service (SMS) text messages and other electronic message from DermCARE Practitioners at the residential or cellular telephone number provided or an appropriate email address, in order to communicate appointment reminders, and notifications regarding the availability of pathology or laboratory results.

(Check all that apply): ☐ Do Not Email ☐ Do Not Text

Photography Release

I consent for medical photographs to be taken of me/ my child/ the person for whom I am legally authorized to represent. I understand that the information will be used in my personal medical record for documentation purposes. Refusal to consent to photographs will in no way affect the medical care I will receive.

Release of Medical Information

I authorize DermCARE Practitioners to release medical information (including chart notes, lab results, pathology results) to my primary care physician and/or specific health care providers requesting such information in regards to my health care.

I also authorize my health care provider to release confidential medical information, on my behalf to my insurance carriers and their employees in order to evaluate my insurance, reimbursement, and coverage for office visits and treatment.

I assert that I am a legal adult of 18 years of age or older and that if I am signing for a minor I am a legal guardian of the identified minor. I authorize DermCARE Practitioners to release medical information over the telephone to the following:

☐ MYSELF ONLY OR ☐ Other (PLEASE PRINT):

RELATIONSHIP	NAME	PHONE
☐ SPOUSE/ SIGNIFICANT OTHER	_____	_____
☐ CHILDREN	_____	_____
☐ PARENT/ GUARDIAN	_____	_____
☐ OTHERS	_____	_____

Notice of Privacy Practices

By signing this, you acknowledge receipt of the "Notice of Privacy Practices" of DermCARE Practitioners. Our notice provides information about how we may use and disclose your protected health information. You have the right to review our notice before signing this consent. We encourage you to read it in full. Our notice is subject to change.

I acknowledge that I have read and agree to be bound by the terms and office policies stated above.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (include relationship) Date

NAME_____ DOB_____ TODAY'S DATE_____

ARE YOU A ☐ NEW OR ☐ ESTABLISHED PATIENT OF CHRISTY Q BAKER

REASON FOR VISIT -PRIORITY #1:_____

LOCATION:_____WHEN DID SYMPTOMS BEGIN:_____

PREVIOUS TREATMENTS (OTC, PRESCRIPTIONS OR OTHER?):_____

PRIORITY #2:_____

LOCATION:_____WHEN DID SYMPTOMS BEGIN:_____

PREVIOUS TREATMENTS (OTC, PRESCRIPTIONS OR OTHER?):_____

YES	NO	PROBLEM	IF YES, PLEASE EXPLAIN
☐		NONE	
☐	☐	ALLERGIES (SEASONAL)	
☐	☐	ANXIETY/DEPRESSION	
☐	☐	ARTHRITIS/JOINT PROBLEMS	
☐	☐	ASTHMA/RESPIRATORY CONDITION	
☐	☐	BOWEL DISORDER(IBS, CHROHN'S, ETC.)	
☐	☐	CANCER:	
☐	☐	COPD	
☐	☐	DIABETES	
☐	☐	HEART CONDITION	
☐	☐	HEPATITIS B OR C (HAS IT BEEN TREATED?)	
☐	☐	HIGH BLOOD PRESSURE	
☐	☐	HIV/AIDS	
☐	☐	HIGH CHOLESTEROL	
☐	☐	HYSTERECTOMY	
☐	☐	THYROID ISSUES	
☐	☐	LEUKEMIA OR LYMPHOMA	
☐	☐	ORGAN TRANSPLANT	
☐	☐	PROSTATE ENLARGEMENT	
☐	☐	TUBERCULOSIS(TB) (HAS IT BEEN TREATED?)	
☐	☐	OTHER:	

PAST SURGERIES/HOSPITALIZATIONS		
	SURGERY	YEAR
1		
2		
3		
4		

ALLERGIES- LIST ALL (FOOD AND MEDICATION) ALLERGIES AND REACTIONS, IF KNOWN:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SKIN HISTORY		
YES	NO	PROBLEM
☐	☐	ACNE
☐	☐	BASAL CELL CARCINOMA
☐	☐	ABNORMAL MOLES
☐	☐	ECZEMA
☐	☐	KELOIDS
☐	☐	MELANOMA
☐	☐	PSORIASIS
☐	☐	ROSACEA
☐	☐	SQUAMOUS CELL CARCINOMA
☐	☐	DO YOU WEAR SUNSCREEN DAILY? ☐15 ☐30 ☐50+
☐	☐	HAVE YOU EVER USED A TANING BED?
☐	☐	DO YOU HAVE A FAMILY HISTORY OF MELANOMA?

MEDICATIONS - *IF YOU HAVE A LIST, PLEASE PROVIDE IT TO US SO WE CAN PHOTOCOPY*

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER, & VITAMINS

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Dermatology Medications - List all dermatology medications you are currently using (Including over- the-counter medications, oral, and topical):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

YES	NO	FAMILY HISTORY	FAMILY MEMBER - (MOTHER, FATHER, BROTHER, SISTER, GRANDPARENT)
☐		NONE	
☐		ADOPTED OR UNKNOWN	
☐	☐	ALOPECIA (HAIR LOSS)	
☐	☐	ASTHMA/SEASONAL ALLERGIES	
☐	☐	LUPUS	
☐	☐	DIABETES	
☐	☐	ABNORMAL MOLES	
☐	☐	ECZEMA	
☐	☐	MELANOMA	
☐	☐	NON-MELANOMA SKIN CANCER	
☐	☐	RHEUMATOID ARTHRITIS	
☐	☐	PSORIASIS	
☐	☐	CANCER:	
☐	☐	OTHER:	

DO YOU SMOKE TOBACCO?

☐ YES ☐ NO

_____PACKS PER DAY

FOR _____ YEARS

☐ YEAR QUIT_____

DO YOU DRINK ALCOHOL?

☐ YES ☐ NO

HOW MANY DRINKS PER DAY?

☐ 1 OR LESS

☐ 1-2

☐ 3 OR MORE

HEIGHT_____

WEIGHT_____

YES	NO	**REVIEW OF SYSTEMS**
☐	☐	EXCESSIVE BLEEDING
☐	☐	PROBLEMS WITH HEALING
☐	☐	PROBLEMS WITH SCARING(KELOID)
☐	☐	CHANGING MOLES/LESIONS
☐	☐	ANXIETY/STRESS
☐	☐	HAY FEVER(ALLERGIES)
☐	☐	VISUAL CHANGES
☐	☐	DEPRESSION
☐	☐	JOINT PAIN
☐	☐	THYROID PROBLEMS
☐	☐	RASH
☐	☐	ITCHING
☐	☐	HAIR LOSS
☐	☐	NAUSEA
☐	☐	COUGH

YES	NO	**ALERTS**
☐		
☐	☐	ALLERGY TO ADHESIVE
☐	☐	ALLERGY TO LIDOCAINE
☐	☐	BLOOD THINNERS
☐	☐	PACEMAKER
☐	☐	☐ PREGNANT ☐ PLANNING ☐ NURSING
☐	☐	RAPID HEARTBEAT WITH EPINEPHRINE
☐	☐	HISTORY OF MELANOMA
☐	☐	HEPATITIS ☐ B ☐ C
☐	☐	HIV/AIDS
☐	☐	HISTORY OF ACCUTANE USE
☐	☐	PATIENT HAS AN INTERPRETER
☐	☐	OTHER: