Dermatology Solutions

Debra Fett Desmond, MD Mary Francis Pilcher, MD Kimberly Mancl, MD Kera Browne, NP Cynthia Feagan, NP Jessica Senge, PA-C

History and Intake Form

Chief Complaint:

_____

Treatments/ Medication tried/ outcome:

_____

Past Medical History:

_____

_____

Past Surgical History:

_____

_____

Allergies:

_____

Skin Disease History ***(circle all that apply)***

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

Do you wear Sunscreen? Y / N **If yes, what SPF?** _____

Do you tan in a tanning salon? Y / N

Family History of Melanoma? Y / N **If yes, which relative (s)** _____

Any other family history:

_____

Smoker? Y / N **Former Smoker?** Y / N **If Yes, Date Quit:** _____ **Alcohol?** Y / N **How Many Drinks per Day?** _____

Medication(s) *Use a separate page if necessary*

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Review of Systems (Please elaborate on any problems you might have):

Problems with fever, weight loss, weakness? _____

Problems with eyes, ears, nose, throat? _____

Problems with lungs, chest, heart? _____

Problems with abdomen, digestion? _____

Problems with bones, muscles, tendons, joints? _____

Problems related to brain, mood? _____

QUALITY MEASURES *required for Medicare*

Vaccination Status: Have you received the pneumonia vaccine? Y / N

Have you received the influenza vaccine? Y / N

Advanced Care Plan: Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Y / N

Do you have a living will? Y / N

(CIRCLE) Which statement(s) 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's necessary to save my life.
- Full Cardiopulmonary resuscitation: I want full cardiopulmonary resuscitation efforts to be made

Patient/ Guardian Name Print: _____ **Date:** _____

Patient/ Guardian Signature: _____

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Last Name: _____ First Name: _____ MI: ____ DOB: _____ Preferred Name: _____

Race: _____ Ethnicity: _____ Language: _____ Decline to answer: Y / N

Preferred Contact #: _____ Secondary Contact #: _____ Marital Status: *(circle one)* S M Div. Sep. Widowed

Primary Street Address: _____ City: _____ State: _____ Zip Code: _____

Secondary Street Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Email: _____ Preferred method of contact: ○ Phone ○ Email ○ Letter

Please circle yes or no to authorize we contact you via email for reminders. We will never give out your email address or send personal medical information without your permission: Y / N

Preferred Pharmacy and Location: _____

PCP/ Family Doctor: _____ **Referring Physician:** _____

My medical records may be disclosed to: _____ **(Name and Relationship)**

Detailed test results may be left on voice mail *(circle one)* **YES NO If yes, what phone number may we leave results:** _____

FINANCIAL DISCLOSURE: I understand that I am fully and legally responsible for all charges for services rendered, which include all outstanding balances not covered by my Medicare and/ or commercial insurance companies. I understand there may be certain procedures which my insurance will not cover. These procedures will be discussed with me prior to the procedure, and I understand that I will be fully responsible for those amounts. I understand that I am responsible for all copayments, deductibles, coinsurance and non-covered services. I understand that all payments are due at the time of service. I authorize payment directly to Dermatology Solutions (Dr. Debra Fett Desmond) of my insurance benefits, otherwise payable to me, but not to exceed the balance due of the centers regular charges, I understand that my failure to pay my account or to make suitable financial arrangements to pay my account may result in my account being turned over to a collection agency, in which I will be responsible for charged interest, collection fees, and/ or attorney fees. **For all non-payments going to collections, a thirty percent fee will be added.** I understand my signature authorizes payments to be made and authorizes the release of my medical information to the insurer of agency shown above. I understand that I may receive a copy of this insurance policy for Dermatology Solutions upon request. I hereby consent to the examination, treatment, payment and procedures which may be performed during this and subsequent visits, including emergency treatment deemed necessary by Dermatology Solutions staff.

Patient/ Guardian Name Print: _____ **Date:** _____

Patient/ Guardian Signature: _____

HIPAA (Health Insurance Portability and Accountability Act): I hereby consent to the examination, treatment, payment and procedures which may be performed during this and subsequent visits, including emergency treatment deemed necessary by the Dermatology Solutions staff. We might share your healthcare information with your physician for payment activities related to the care you received. Your PHI (Protected Health Information) may be released to a public health or organization or federal organization in the event of a communicable disease or to report a defective device. Your PHI may be released after receiving written authorization from you, other than those listed above for treatment, payment or healthcare operations. You may revoke your permission to release PHI at any time. It must be in writing with effective date and be specific to the health information being protected. You may be contacted by us via phone or mail (or leave a message on an automated answering device) to remind you of appointments, pre-scheduled procedures, verify insurance/ demographic information, request payment for services rendered or to inform you of test results. You have the right to request a more confidential way of providing your PHI or alternative communication method at the time you are seen. We will honor all reasonable requests. You have the right to receive confidential communication about your health information to notify or assist in the notification of a family member, your personal representative or any other person responsible for your care. You have the right to review and photocopy any/ all portions of your health information. We have the right to assess a fee for photocopying your health information. You have the right to know who has accessed your PHI and for what purpose other than treatment, payment, healthcare operations and other activities.

Patient/ Guardian Name Print: _____ **Date:** _____

Patient/ Guardian Signature: _____