DERMATOLOGY MD

Name:_____ DOB:_____

Address:_____

City:_____State:_____ Zip Code:_____

Phone:_____Email:_____

Emergency Contact Name: _____Phone: _____

Do you give Dermatology MD permission to speak to the person listed above regarding your treatment and care?
Circle one: **YES** **NO**

HIPPA, Payment Policy and Authorization

Our Notice of Privacy Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by request.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
By signing this Form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

Referrals must be obtained prior to the visit. If a referral is not received at the time of the visit, the patient is responsible for payment when services are rendered. We file insurance for our insured patients, however, co-payments and/or deductible amounts are due at the time of service. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim by your insurance company, but rejection/reduction by them does not relieve the financial obligation you have incurred.
I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.
I assign all medical benefits for office visits to Dr. Kesani. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

Signature:_____Date: _____

HISTORY AND INTAKE FORM

Past Medical History: (circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (prostate enlarged)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
Coronary Artery Disease (heart)
Depression
Diabetes
End Stage Renal Disease
GERD (heartburn)
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

Other _____

Past Surgical History: (circle all that apply)

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: (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
Psoriasis
Squamous Cell Skin Cancer

Other _____

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

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s) _____

Review of Systems: Are you currently experiencing any of the following? (Please circle all that apply)

SYMPTOM	SYMPTOM	SYMPTOM
Abdominal Pain	Headaches	Wheezing
Anxiety	Hay Fever	Immunosuppression
Bleeding Problems	Joint Aches	Unintentional weight loss
Bloody Stool Bloody	Muscle Weakness	Significant UV Exposure
Urine Blurry Vision	Neck Stiffness	Allergy to Adhesive
Changing Mole	Rash	Allergy to Lidocaine
Chest Pain	Seizures	Allergy to Topical Antibiotic
Cough Depression	Shortness of Breath	MRSA
Fever or Chills	Sore Throat	History of Fainting
Night Sweats	Thyroid Problems	History of Vasovagal

Other Symptoms: _____

Do you have any upcoming physical events or travel plans? _____

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No
If yes, when and what bodylocations? _____		
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No
Are you pregnant or currently trying to get pregnant?	Yes	No

If you circled No, how are you preventing?_____

Social History:

Do you smoke? Yes No
If yes, how much? _____

Do you drink any alcohol? Yes No
If so, how much? _____

Do you use any recreational drugs? Yes No
If so, which ones? _____

Occupation: _____

PHARMACY NAME:_____

ADDRESS:_____

PHONE: _____

MEDICATIONS: (If you have a list, please provide it to the front desk)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: (Please list below or write NONE)

_____