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| --- |
| Last Name \_ First Name Middle Initial \_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_ Age Sex (Circle one) M F Address \_City State Zip Home Phone # Cell Work  Marital Status (circle one) Single Married Separated Divorced Widow  Place of Birth (City,State): How did you hear about us? Email  Occupation: Employer: Industry:  Race: Ethnicity: Language:  Primary Care Physician: (First Name) (Last Name) Phone Address  Referring Physician: (First Name) (Last Name) Phone Address  **In case of emergency**  Name Relation Phone  **Please list your local pharmacy:** (For e-prescribing purposes)  Pharmacy Name: Phone #: Address: |
| Primary Insurance ID number Subscriber Name Subscriber DOB SS# Patient’s relationship to subscriber: Self Spouse Child Other  Secondary Insurance ID number\_ \_  Subscriber Name Subscriber DOB SS# Patient’s relationship to subscriber: Self Spouse Child Other |
|  |
| **Please CIRCLE all that apply** |
| **PAST MEDICAL HISTORY: NONE**  Anxiety COPD HIV / AIDS  Arthritis Coronary Artery Disease Hypercholesterolemia  Asthma Depression Hypertension  Atrial Fibrillation Diabetes Hyperthyroidism (overactive)  BPH End Stage Renal Disease Hypothyroidism (underactive) Bone Marrow Transplantation GERD Leukemia  Breast Cancer Hearing Loss Lung Cancer  Colon Cancer Hepatitis Lymphoma  Prostate Cancer Radiation Treatment Seizures Stroke  Other Important Medical History: |
| The above information is true to the best of my knowledge.  Patient or Parent/ Guardian Signature Date |

**NAME:**

**(please circle all that apply)**

**PAST SURGICAL HISTORY: NONE**

Appendix (Appendectomy) Bladder (Cystectomy)

Breast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gallbladder Removed

Heart: Coronary Artery Bypass (CABG) Ovaries Removed: Cancer

Brain Surgery

Uterus (Hysterectomy): Fibroids

Uterus (Hysterectomy): Uterine Cancer

Ovaries Removed: Endometriosis

Heart: PTCA (Angioplasty)

Heart: Mechanical Valve Replacement Heart: Biological Valve Replacement Heart Transplant

Knee Replacement: (Right, Left, Bilateral) Hip Replacement: (Right, Left, Bilateral) Kidney Biopsy

Kidney Removed: (Right, Left) Kidney Stone Removal

Kidney Transplant

Ovaries Removed: Cyst Prostate Removed: Cancer Prostate Biopsy

Prostate: TURP Skin Biopsy

Skin: Basal Cell Carcinoma Surgery Skin: Squamous Cell Carcinoma Surgery Skin: Melanoma Surgery

Spleen Removed

Testicles Removed (Right, Left, Bilateral)

Other Important Surgical History and dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN DISEASE HISTORY:**

Acne Flaking Or Itchy Scalp Warts Dry Skin

Actinic Keratosis Squamous Cell Skin Cancer Impetigo Precancerous Moles

Basal Cell Skin Cancer Melanoma Eczema Cold Sores

Blistering Sunburns Other infection Poison Ivy Psoriasis Other: Nail disorder Allergic reactions Hair loss Keloid scar

**NONE**

**Basal cell carcinoma or Squamous cell carcinoma :**

Year:\_ Location:\_ Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year:\_ Location:\_ Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year:\_ Location:\_ Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Melanoma:** Year:\_ Location: Treatment**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you wear Sunscreen?** Yes No **What SPF? Do you have a family history of Melanoma?** Yes No Who?

**Tanned in a tanning salon?** Yes No

**(please circle all that apply)**

**Review of Systems:**

Changing mole Thyroid Problems Cough Neck stiffness

Rash Hepatitis Depression Night sweats Problems with scarring HIV / AIDS Fever or chills Seizures

Problems with healing Abdominal pain Headaches Shortness of breath Problems with bleeding Anxiety Hay Fever Sore throat

Bloody stool Immunosuppression Unintentional weight loss Bloody urine

Joint aches Wheezing Muscle weakness Chest pain

Pregnancy or planning pregnancy Blurry vision

# NONE

**Alerts:**

Allergy to adhesive Allergy to latex Allergy to lidocaine

Allergy to topical antibiotic ointments Artificial heart valve

Artificial joints in the last two years

Blood thinners Defibrillator MRSA

Pacemaker

Personal history of atypical moles

Pregnant or planning pregnancy

Allergy to epinephrine history Personal of Melanoma Premedication prior to procedures Rapid heartbeat with epinephrine

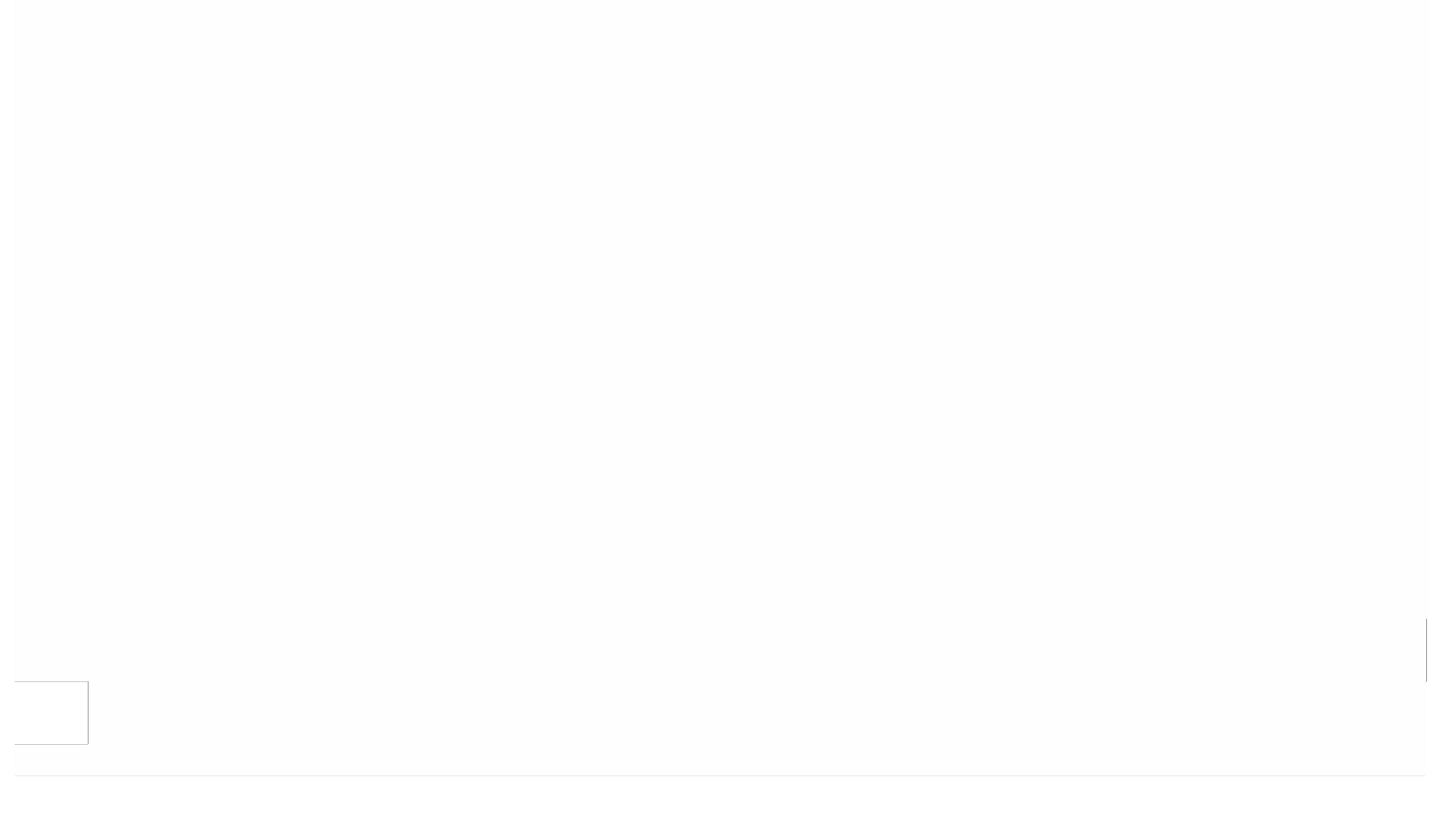
Breastfeeding

# NONE

The above information is true to the best of my knowledge.

# Patient or Parent/ Guardian Signature Date

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**PRESCRIPTION OR OVER THE COUNTER MEDICATIONS/SUPPLEMENTS:**

Dose: Dose: Dose: Dose:

Dose:

**NONE**

Dose:

Dose:

Dose:

Dose:

Dose:

A**LLERIGIES TO MEDICATIONS:** (please list drug allergies)

**NONE**

**SOCIAL HISTORY**: (please circle all that apply)

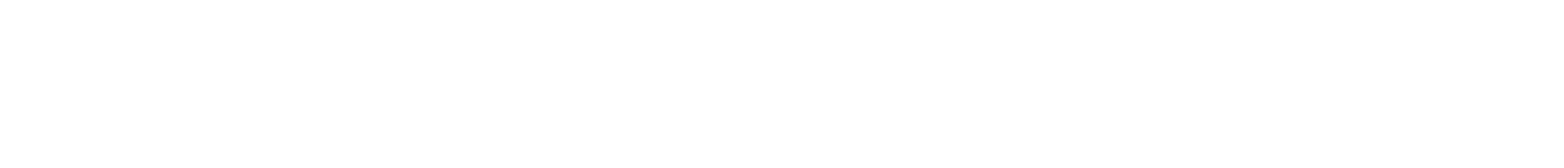
**IV Drug/ Drug Use:** Yes No **Smoking Use:** Never

Currently Smokes - daily Currently Smokes - not daily Has smoked in the past

**Alcohol Use:** None

less than 1 drink/day 1-2 drinks/day

3 or more drinks /day



The above information is true to the best of my knowledge.

Patient or Parent/ Guardian Signature Date

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am responsible for any balance. I also authorize Connolly Dermatology or the insurance company to release any information required to process my claims.

Patient or Parent/ Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:**

## CO-PAYMENT AND DEDUCTIBLES

Payment is required for all services at the time they are rendered. Co-payments will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. I further acknowledge that I am responsible for the co-insurance and/or deductible under my health plan’s agreement and should my account be sent to a collection agency, I shall be responsible for the collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy.

## REFERRAL POLICY

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and ensure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, I will need to reschedule my appointment.

## INSURANCE CARDS

All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

## CANCELLATION POLICY

Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 24 hours prior to the appointment will result in a $25.00 no-show fee. This fee is not reimbursable by your insurance company.

**Patient Signature:** Date:

## HIPAA POLICY

Patients 18 years of age or older are protected under the Federal **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct. This federal law prohibits any staff member of **Connolly Dermatology** from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition or obtain results for you, please list their name(s) below. Only individuals whose names are listed will be provided with information. Should you wish to update the names provided, please ask the receptionist at the front desk for a HIPPA form.

Name of Individual (please print) Relationship to Patient Name of Individual (please print) Relationship to Patient

If we are unable to reach you may we leave a message on voicemail? YES NO

If we are unable to reach you may we leave a message with a person? YES NO

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review the Notice of Privacy. I understand a copy of the Privacy Practices is available upon my request ).

**Patient Signature:** Date:

## Must be signed by patient 18 years or older. Patients under 18, must be signed by a parent or legal guardian.

Cosmetic Interest Questionnaire

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health issues and procedures or products of interest to you (please check all that apply).**

* Free Visia Complexion Analysis
* Micro-Dermabrasion
* Chemical Peels
* Facial and Eye Treatments
* BOTOX®
* Juvederm®
* Skin Care Advice -
* Sunscreen Advice
* Skin Care Products
* Cellulite Therapy
* Acne Products
* Anti-aging Products

* Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.**

*When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.*

Younger Than True Age Older Than

1 2 3 4 5

*When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.*

Not Concerned Somewhat Concerned Very Concerned

*1 2 3 4 5*

**How did you hear about us?**

❑ My physician (full name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ An advertisement (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ A friend or family member (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Another person not listed above (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the name of and address of the person who referred you so we can thank them. *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*❑ Internet*

*❑ A seminar where I saw a physician. The event took place on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at*

*(location) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*



**HIPAA Patient Consent Form**

This notice of Privacy Practices describes how we may use and disclose your health information to carry out treatment, payment or health care operations and any other purposes that are permitted or required by law. It describes your right to access and control your protected health information. “Protected health information” is any information about you, including demographic information, that may identify you and relate to your past, present or future health or condition and related services.

**USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by Connolly Dermatology, our office staff and anyone that is involved in your care and treatment for the purpose of providing health care service to you, to pay your health care bills, to support the operations of the physician’s practice, and any other use required by law. These uses may include, but are not limited to, coordinating or managing your health care and related services with a third party, to obtain payment for your health care services, staff training purposes, to contact you to remind you of your appointment, using a sign in sheet at the registration desk and calling you by name in the waiting room when your provider is ready to see you.

**OTHER USES AND DISCLOSURE WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION:**

We may use or disclose your protected health information in the following situations without your authorization. These situations might include: as required by law, public health issues as required by law, communicable diseases, abuses or neglect, FDA requirements and any matter required by law.

**YOUR RIGHTS:**

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information complied in reasonable anticipation of, or use in a civil criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request my state specific restrictions requested and to whom the restrictions apply. Connolly Dermatology is not required to agree to a restriction request.

**COMPLAINTS**

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager. If you have any objections to this form, please ask to speak with our Office Manager.