CONNOLLY DERMATOLOGY

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)

Primary Insurance_____ID number _____

_____ Subscriber Name

_____Subscriber DOB_____S S #

_____ Patient's relationship to subscriber: Self Spouse Child

Other

Secondary Insurance_____ID number_____

Subscriber Name_____Subscriber DOB_____S S #

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
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Other:
Hair loss
NONE

Flaking Or Itchy Scalp
Squamous Cell Skin Cancer
Melanoma
Other infection
Nail disorder
Keloid scar

Warts
Impetigo
Eczema
Poison Ivy
Allergic reactions

Dry Skin
Precancerous Moles
Cold Sores
Psoriasis

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?** _____ **Tanned in a tanning salon?** Yes No
Do you have a family history of <u>Melanoma</u>? Yes No Who?

(please circle all that apply)

Review of Systems:

Changing mole
Rash
Problems with scarring
Problems with healing
Problems with bleeding
Bloody stool
Joint aches
Pregnancy or planning pregnancy

Thyroid Problems
Hepatitis
HIV / AIDS
Abdominal pain
Anxiety
Immunosuppression
Wheezing
Blurry vision

Cough
Depression
Fever or chills
Headaches
Hay Fever
Unintentional weight loss
Muscle weakness

Neck stiffness
Night sweats
Seizures
Shortness of breath
Sore throat
Bloody urine
Chest pain

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: **NONE**

_____ Dose: _____ _____ Dose: _____

_____ Dose: _____ _____ Dose: _____

_____ Dose: _____ _____ Dose: _____

_____ Dose: _____ _____ Dose: _____

_____ Dose: _____ Dose: _____

ALLERIGIES 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 _____

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.

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 _____

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) _____.*

CONNOLLY DERMATOLOGY

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.