CENTER FOR
Dermatology &
Plastic Surgery

TODAY'S DATE: _____ OFFICE: _____ PRIMARY LANGUAGE: _____

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE)

CHECK ONE :
☐ MALE
☐ FEMALE

CHECK ONE :
☐ SINGLE ☐ WIDOWED
☐ MARRIED ☐ DIVORCED

ETHNICITY: _____

RACE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____ PHONE: _____
(IF PATIENT IS A MINOR)

PATIENT'S LOCAL ADDRESS: _____
(STREET) (UNIT) (CITY) (ZIP)

PERMANENT ADDRESS (IF DIFFERENT): _____

PREFERRED #
☐ HOME
☐ CELL

HOME #: _____

CELL #: _____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON EITHER PHONE # LISTED?
☐ YES ☐ NO

EMAIL: _____ MAY WE EMAIL MEDICAL INFORMATION? ☐ YES ☐ NO

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: _____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH A FAMILY MEMBER?

☐ NO ☐ YES → IF YES, WHOM? NAME: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY INSURANCE COMPANY: _____

POLICY / ID # _____ GROUP # _____

POLICY HOLDER: _____ RELAIONSHIP: _____

POLICY HOLDER'S DATE OF BIRTH: _____ SOCIAL SECURITY # _____

SECONDARY INSURANCE COMPANY: _____

POLICY / ID # _____ GROUP #: _____

POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

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MEDICAL HISTORY

NAME _____ **DOB** _____ **AGE** _____ **DATE** _____

HEIGHT _____ **WEIGHT** _____ **OCCUPATION** _____

PAST MEDICAL HISTORY (Please check all that apply)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Bone Marrow
- ❑ Transplantation
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ High Blood pressure
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ NONE
- ❑ Other _____

PAST SURGICAL HISTORY (Please check all that apply)

- ❑ Appendix Removed
- ❑ Bladder Removed
- ❑ Mastectomy (Right, Left, Bilateral)
- ❑ Lumpectomy (Right, Left, Bilateral)
- ❑ Breast Biopsy (Right, Left, Bilateral)
- ❑ Breast Reduction
- ❑ Breast Implants
- ❑ Facial Plastic Surgery
- ❑ Liposuction
- ❑ Tummy Tuck
- ❑ Colectomy: Colon Cancer Resection
- ❑ Colectomy: Diverticulitis
- ❑ Colectomy: IBD -Gallbladder Removed
- ❑ Coronary Artery Bypass
- ❑ 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 (Nephrectomy)
- ❑ 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 (Prostate Removal)
- ❑ Spleen Removed
- ❑ Testicles Removed (Right, Left, Bilateral)
- ❑ Hysterectomy: Fibroids
- ❑ Hysterectomy: Uterine Cancer
- ❑ NONE
- ❑ Other _____

SKIN DISEASE HISTORY: (Please check 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
- ❑ NONE
- ❑ 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, in who? _____

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MEDICATIONS (list all) _____

_____

ALLERGIES (list all) _____

_____

SOCIAL HISTORY: (Please check all that apply)

Cigarette Smoking:
- ❑ Currently Smokes
- ❑ Former Smoker
- ❑ Never smoked
- ❑ Use other tobacco products

Alcohol Use:
- ❑ EtOH - None
- ❑ EtOH - <1 drink per day
- ❑ EtOH - 1-2 drinks per day
- ❑ EtOH - >3 drinks per day

Married ❑ Yes ❑ No
Children ❑ Yes ❑ No

SERIOUS FAMILY ILLNESSES _____

_____

Preferred language:_____ Race: _____ Ethnicity: _____
Preferred Pharmacy: _____ Phone# _____ City or Zip Code: _____

REVIEW OF SYSTEMS (Please check any symptoms you are currently experiencing)

- ❑ NONE
- ❑ Immunosuppression
- ❑ Hay Fever
- ❑ Chest Pain
- ❑ Fever or Chills
- ❑ Night Sweats
- ❑ Unintentional Weight Loss
- ❑ Thyroid Problems
- ❑ Sore Throat
- ❑ Blurry Vision
- ❑ Abdominal Pain
- ❑ Bloody Stool
- ❑ Bloody Urine
- ❑ Problems with Bleeding
- ❑ Other Skin Complaints
- ❑ Other_____
- ❑ Problems with Healing
- ❑ Problems with Scarring
- ❑ Rash
- ❑ Joint aches
- ❑ Muscle Weakness
- ❑ Neck Stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ HIV Positive
- ❑ Allergy to Epinephrine
- ❑ Allergy to Lidocaine
- ❑ Allergy to Topical Antibiotics
- ❑ Allergy to Adhesive
- ❑ Allergy to Latex
- ❑ Artificial Heart Valve
- ❑ Artificial Joints w/in last 2yrs
- ❑ Blood thinners
- ❑ Defibrillator
- ❑ MRSA
- ❑ Pacemaker
- ❑ Requires Premedication prior to Procedures
- ❑ Rapid Heart Beat with Epinephrine
- ❑ Pregnant or trying
- ❑ Anxiety
- ❑ Depression
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Wheezing

How did you hear about us? _____
Can we thank them? ❑ Yes ❑ No

CENTER FOR
Dermatology &
Plastic Surgery

AUTHORIZATION TO RELEASE INFORMATION TO PAY BENEFITS TO CENTER FOR DERMATOLOGY & PLASTIC SURGERY

I hereby authorize Center for Dermatology & Plastic Surgery (CFDPS) and its employees and agents to release my medical records documenting my examination and treatment, including AIDS related testing, psychiatric, or substance abuse information, upon valid request.

I hereby assign payment directly to CFDPS for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to CFDPS for all charges in the event that I have no insurance, or my insurance is rejected, and for any balance or fee not covered by my insurance and/or deemed my responsibility. I understand and acknowledge that if CFDPS files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket costs" are only an estimate and that the exact determination of my financial responsibilities will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment include check, cash, and credit card.

Cancelation Policy for Dermatology: If you fail to attend your scheduled appointment a fee of $35 will be charged to your account.
Cancelation Policy for Plastic Surgery: If you fail to attend your scheduled appointment, and do not cancel/reschedule prior to 48 hours of your appointment, there will be a fee of $75 will be charged to your account.

I further agree to pay all costs of collections, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Arizona. I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests, or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric, or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

I understand that my CFDPS physician has a financial interest in the CFDPS Pathology, CFDPS Pharmacy, and all other CFDPS facilities to which I may be referred. I acknowledge that I may receive these services at an CFDPS facility or other facilities whose names and addresses I have been provided.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize CFDPS physicians, practitioners, and their staff to conduct any diagnostic examinations, tests, and procedures, and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose, and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options, as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular exam, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

HIPAA PATIENT CONSENT

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. A copy of our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Center For Dermatology & Plastic Surgery provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent.
- Protected health information may be used for treatment through one of you current doctors, payment with your insurance company or healthcare operations within our office.
- Center For Dermatology & Plastic Surgery has a Notice of Privacy Practices that is available for review.
- Center For Dermatology & Plastic Surgery reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but Center For Dermatology & Plastic Surgery does not have to agree to these restrictions if, for example it interferes with payment, daily operations or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Center For Dermatology & Plastic Surgery may condition treatment upon the execution of this consent.
- You have the right to be notified of a protected health information breach
- Center For Dermatology & Plastic Surgery cannot sell your health information without your permission.
- Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practice will only be made with your authorization.

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

PRINT PATIENTS FULL NAME

PATIENT SIGNATURE (OR GUARDIAN IF PT IS A MINOR)

DATE

WITNESS SIGNATURE

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or patient's personal representative. I have made a good faith effort to obtain a written acknowledgment of receipt of Center For Dermatology & Plastic Surgery Notice of Privacy Practices but was unable to for the following reason:

Patient refused to sign_____ Patient unable to sign _____ Other:_____

Employee Name:_____ Date:_____