Welcome to Premier Dermatology!

Please fill out the information below prior to your visit. We recommend you complete this information online at our patient portal www.premierdermdocs.ema.md . Please call us and we will email your personal access information.

NOTE: If you have an HMO plan, you are responsible for obtaining a Referral from your primary care physician prior to your visit or we may have to reschedule your appointment.

PATIENT INFORMATION

Arrival Date: _____ ***Arrival Time:*** _____ ***Note: Checked-in time starts once all forms are completed***	***Social Security*** *(Required):*	❑***Male*** ❑***Female***	***Birthday*** *(mm/dd/yy)*

Patient Name (First, Middle, Last)	*Name of Responsible Party (patient, parent, guardian, POA) Circle one*
Mailing Address	*Mailing / Secondary/ Billing/Guardian/POA address (circle one)*
City/State/Zip	*City/State/Zip*
Patient Email Address	***Emergency Contact/Parent /Guardian***
Home Phone# / *Cell Phone#*	*Phone* / *Relationship*

How did you hear about us?
❑Website/Internet ❑Newspaper ❑Yellow Pages
❑ Friend/Family ❑Mailer ❑Doctor
❑Insurance Plan ❑Window sign ❑ Other _____

Primary Language: ❑English ❑Spanish ❑Other_____
Hispanic or Latino:? ❑Yes ❑No
Ethnicity: ❑White ❑Black/African American ❑Asian
❑American Indian/Alaska ❑ Hawaiian/Pacific Islander

If you DO NOT wish to receive any reminders, cards, information, marketing and fundraising material by mail from our practice, Write PRIVATE: _____

Your Email Address is kept CONFIDENTIAL - if you do not wish to receive email from our practice, Write the PRIVATE here: _____

INSURANCE INFORMATION

Primary Insurance	***Secondary Insurance***
Member ID# ***Group#***	***Member ID#*** ***Group#***
Subscriber's Name	***Subscriber's Name***
Subscriber's DOB ***SS#***	***Subscriber's DOB*** ***SS#***
Subscriber Relationship to patient	***Subscriber Relationship to patient***

Please present your insurance card(s) and a photo ID to the receptionist. *These will be copied and placed in your medical record for identification purposes and for protection of your Private Health Information. Photo ID of parent/guardian requested for minor or if patient unable to consent.*

EMPLOYER	PRIMARY CARE PHYSICIAN	PHARMACY
Name	***Name***	***Name/Location***
Phone	Phone	Phone

Did a Doctor refer you to us? YES / NO If YES, Name _____ Phone # _____

REASON FOR TODAY'S VISIT:_____

What is your occupation?	**What are your hobbies**?
Marital Status ❑Single ❑Married ❑Widowed ❑Other	**Household Members** (including yourself): _____

Do you drink alcohol? ❑Yes ❑No	**Do you smoke Cigarettes/Cigars?**	**Do you use illicit drugs?** ❑Yes ❑No
If yes,❑LESS or ❑MORE than 7 glass/week ❑LESS or ❑MORE than 14 glass/week	❑Never smoked ❑Yes, ___ cig/day ❑I quit,____ ❑day ❑mth ❑yr ago Other Type of Tobacco:_____	**If yes,** what type and how often?

WE RECOMMEND A FULL BODY EXAM FOR ALL OUR NEW PATIENTS TO SCREEN FOR SKIN CANCER AND TO ALL OUR PATIENTS DIAGNOSED WITH SKIN CANCER IN THE PAST.

Do we have permission to: Leave a message on your answering machine ❑No ❑Yes at ❑Home ❑Cell

Discuss your medical condition with household member: ❑No ❑Yes To whom: _____Relationship _____

PATIENT INITIALS

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth:_____

Reason for today's visit:_____ **Pain** (circle one): 1 2 3 4 5 6 7 8 9 10 (1= uncomfortable - 10= unbearable)

CURRENT MEDICATIONS TAKING (prescriptions, over-the-counter meds, vitamins, herbal treatments) *Use back of form if needed*

Name	Strength	Route	Dose	Frequency	Name	Strength	Route	Dose	Frequency

DO YOU HAVE, OR HAD ANY OF THE FOLLOWING CONDITIONS? *Check only those that apply & write Location/Date*

Past Medical History — *Area/Year*

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation _____
- ❑ Bone Marrow Transplantation _____
- ❑ BPH (prostate enlargement) _____
- ❑ Breast Cancer _____
- ❑ Colon Cancer _____
- ❑ Chronic Obstructive Pulmonary disease
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD (acid reflux, heartburn)
- ❑ Hearing Loss
- ❑ Hepatitis _____
- ❑ Hypertension
- ❑ HIV/AIDS _____
- ❑ Hypercholesterolemia _____
- ❑ Hyperthyroidism _____
- ❑ Hypothyroidism _____
- ❑ Leukemia _____
- ❑ Lung Cancer _____
- ❑ Lymphoma _____
- ❑ Prostate Cancer _____
- ❑ Radiation Treatment _____
- ❑ Seizures _____
- ❑ Stroke _____
- ❑ OTHER: _____

Skin Disease History

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer_____
- ❑ Blistering Sunburn (s)
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma _____
- ❑ Poison Ivy _____
- ❑ Precancerous Moles _____
- ❑ Psoriasis _____
- ❑ Squamous Cell Skin Cancer_____
- ❑ OTHER: _____

Medical conditions or recent surgery (within last 6 months):

_____
_____
_____
_____

Past Surgical History — *Area/Year*

- ❑ Appendix Removed _____
- ❑ Bladder Removed _____
- ❑ Breast Biopsy (Right, Left, Both) _____
- ❑ Lumpectomy (R, L, B) _____
- ❑ Mastectomy (R, L, B) _____
- ❑ Colon Cancer Resection _____
- ❑ Colectomy: Diverticulitis
- ❑ Inflammatory Bowel Disease _____
- ❑ Gallbladder Removed _____
- ❑ Biological Valve Replacement _____
- ❑ Coronary Artery Bypass Surgery _____
- ❑ Heart transplant _____
- ❑ Mechanical Valve Replacement _____
- ❑ Heart: PTCA _____
- ❑ Hip Joint Replacement (R, L, B) _____
- ❑ Knee Joint Replacement (R,L,B) _____
- ❑ Kidney Biopsy
- ❑ Kidney Transplant _____
- ❑ Kidney: Nephrectomy _____
- ❑ Liver: Hepatectomy _____
- ❑ Liver Transplant _____
- ❑ Liver Shunt _____
- ❑ Ovaries Removed _____
- ❑ Ovarian Cancer Removed _____
- ❑ Ovarian Cyst Removed _____
- ❑ Tubal Ligation _____
- ❑ Pancreas: Pancreatectomy _____
- ❑ Prostate Biopsy
- ❑ Prostate Cancer _____
- ❑ Prostate: TURP _____
- ❑ Rectum: APR _____
- ❑ Skin: Basal Cell _____
- ❑ Skin: Melanoma _____
- ❑ Skin Biopsy _____
- ❑ Skin: Squamous Cell _____
- ❑ Spleen Removal _____
- ❑ Testicles Removal _____
- ❑ Hysterectomy: Fibroids _____
- ❑ Hysterectomy Uterine Cancer _____
- ❑ Hysterectomy Cervical Cancer_____
- ❑ OTHER: _____

Current Influenza Immunization: ❑Yes ❑No
We recommend yearly immunization

Vaccinated for Pneumonia: ❑Yes ❑No

Do you use sunscreen? ❑ Yes: SPF___ ❑No

Do you go to tanning salon? ❑ Yes ❑ No

Are you pregnant? ❑Yes:_____ ❑No ❑Maybe
Due date

Review of Systems (current symptoms)

- ❑ Fever or chills
- ❑ Unintentional weight loss
- ❑ Night sweats
- ❑ Immunosuppression (low immune system)
- ❑ Enlarge lymph nodes
- ❑ Problem with bleeding
- ❑ Problem with healing
- ❑ Problem with scarring (keloids)
- ❑ Rash
- ❑ New or Changing mole
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Sore throat
- ❑ Blurry Vision
- ❑ Thyroid problems
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Bloody urine
- ❑ Joint aches
- ❑ Muscle weakness
- ❑ Neck stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ Anxiety
- ❑ Depression

ALERT

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ Premedication before procedures
- ❑ Artificial heart valve
- ❑ Artificial joints within the past 6 months
- ❑ Allergy to lidocaine (Xylocaine)
- ❑ Rapid heartbeat with epinephrine
- ❑ Allergy to adhesive/tape
- ❑ Allergy to topical antibiotic ointments
- ❑ Blood thinners
- ❑ MRSA (staph infection)
- ❑ Pregnancy or planning pregnancy
- ❑ Hospice
- ❑ OTHER: _____

Do you know any "blood relative" who has/had skin cancer? ❑ Yes ❑ No
Type & whom?_____
_____

Allergies: ❑ NONE (or list all Allergies)
_____
_____
_____

Do you have any cosmetic concerns? ❑ Yes ❑ No Explain: _____
Would you like to speak with our Aesthetician about products/appearance? ❑ Yes ❑ No Explain: _____-

Patient Signature/POA/Guardian: _____ **Name:** _____ **Date:**_____
Form Completed by: ❑ **Patient** ❑ **Nurse/MA - Initials:**

 nwv0317

Facial Questionnaire

Please answer the following questions about your personal facial history:

1. Do you have any concerns with your skin you would like addressed today? ❑ Yes ❑ No

_____

2. What skin care products are you currently using on your skin? _____

3. List all glycolic, salicylic, or other treatments/products you currently use or have used in the past:

_____

4. Do you have any allergies to any skin care products or ingredients? _____

5. Have you ever had any type of chemical peel? ❑ Yes ❑ No If Yes, when: _____

6. Have you ever had a microdermabrasion treatment? ❑ Yes ❑ No If Yes, when: _____

7. Are you currently on any hormones or Birth Control? ❑ Yes ❑ No If Yes, when: _____

8. Are you currently using Retin-A or have you used it in the past 3 months? ❑ Yes ❑ No If Yes, when: _____

9. Are you currently using Accutane or have you used it in the past 3 months? ❑ Yes ❑ No If Yes, when: _____

10. Do you currently suffer from or have you suffered in the past from (check all that apply):

❑Cystic Acne ❑Acne ❑Rosacea ❑Hormonal Problems ❑Oral Herpes ❑Cold Sores ❑Fever Blisters

If yes to any, how often? _____ How do you treat it? : _____

11. Have you had any plastic surgery or laser treatments in the past 3 months? ❑ Yes ❑ No

If yes what? _____ When? _____

12. What kind of outdoor activities do you regularly engage in? : _____

13. How much water do you drink a day? _____ Glasses per day

14. Do you use sunscreen? ❑ Yes ❑ No SPF_____ If yes, how often?

_____

15. Are you pregnant or might be pregnant? ❑ Yes ❑ No Are you currently nursing? ❑ Yes ❑ No

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:	Younger Than		True Age		Older Than
I believe I look younger, the same as, or older than my true age.	1	2	3	4	5
	Not concerned	Somewhat	Concerned	Very Concerned	
How concerned are you about the appearance of your wrinkles?	1	2	3	4	5

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

❑ Botox / Dysport / Xeomin	❑ Photo Dynamic Therapy Acne	❑ Skin Care Advice or Products
❑ Facial fillers, volumizers	❑ Photo Dynamic Therapy Age Spot	❑ Retin-A or Renova
❑ Lip enhancement	❑ Acne Treatment	❑ Sunscreen Advice
❑ Removing Facial Veins	❑ Laser procedures _____	❑ Facial Treatments /Peels
❑ Spider Vein Treatments (Legs)	❑ Liver Spots / Age Spots treatment	❑ Microdermabrasion/ Dermaplaning
❑ Skin Rejuvenation	❑ Birthmarks	❑ Other: _____

Patient Name: _____ Signature: _____ Date: _____

PATIENT BILLING CONSENT FORM

If you are a minor, uninsured, insured with a non- participating insurance (including non-QMB Medicaid patients), have an outstanding balance or had a past delinquent account, please fill out the form below.

Patient Name: _____ Date of Birth _____

IF PATIENT IS UNABLE TO CONSENT, GUARDIAN/PARENT MUST COMPLETE THE FOLLOWING:

Patient is unable to consent because: _____ I hereby consent on his/her behalf and in his/her stead. I am responsible for any medical expenses incurred by this patient ☐ YES ☐ NO.

Name: _____ Relationship to patient: _____
First Name Middle Last Name

Date of Birth: ___/___/_____ Social Security Number: _____ Primary Phone Number: _____
Month Date Year

Billing Address: _____ City / State: _____ Zip code: _____

Please present your photo ID to the receptionist. *Used for identification purposes and for protection of your Private Health Information.*

Signature: _____ **Date:** _____

Name on Card if Different: _____

Card Number: _____ Exp. Date: _____ Security Code: _____

Card Holder's Billing Address for Monthly Card Statements:

_____
Street City State Zip Code

I authorize Abrams Dermatology to charge my Credit card for professional services as follows:

- ❑ Full Fee for Service $_____
- ❑ Co-pay Amount or Fees towards Insurance Deductible $_____
- ❑ Outstanding Balance $_____
- ❑ Other $_____ - Description: _____

Special Note: _____

_____

_____

Please be aware that unless an agreement is negotiated with the above provider all outstanding balances not paid within 30 days, after a bill is sent or the insurance company has notified you or this office of your balance, will be charged to your credit card.

Card Holder's Signature: _____ Date: _____

Please note that all information will be kept confidential and that information will only be used to obtain payment for services.

RELEASE OF PHI

Your privacy is important to us. We record information about you so that we may provide quality medical care. *Premier Dermatology* is committed to protecting this information. The notice of Privacy Practices describes your rights with regards to your health information and how we must protect the confidentiality of that information. **This is a summary of the more detailed information contained in our Notice of Privacy Practices. A copy of the Complete Notice of Privacy Practices at The Center for Skin Wellness and the office of Robert Finkelstein D.O. (a copy is located at the reception desk).**

Your Rights Include: (When limitations and written authorization are applicable)

- Right to Inspect and Copy
- Right to a Summary or Explanation
- Right to an Electronic copy of Medical Records
- Right to get Notice of a Breach
- Right to Request Amendments
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Out-of-Pocket Payments (in certain circumstances, you may not want us to bill your insurance)
- Right to Request Confidential Communications
- Right to a Paper Copy of this Notice

We may use your health information and/or records to:
(When applicable requirements are met)

- For Treatment
- For Payment
- For Healthcare Operations
- Appointment Reminders/Treatment Alternatives/Heath-Related Benefits and Services
- Minors
- As Required by Law
- To Avert a Serious Threat to Health or Safety
- Business Associate
- Organ and Tissue Donor
- Military and Veterans
- Workers' Comp
- Public Health Risk
- Abuse, Neglect, or Domestic Violence
- Health oversight activities
- Data Breach Notification Purposes
- Lawsuits and Disputes
- Law Enforcement
- Military Activity and National Security
- Coroners, Medical Examiners, and Funeral Directors
- Inmates

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- Individuals Involved in Your Care or Payment for your care
- Disaster Relief
- Fundraising activities

Everyone in our office who has access to your information is trained and bound by a confidentiality requirement and signs an agreement. Besides you, is there another person we may speak to about your health care and lab results?

If yes, list: (use back of the form)

Last Name: _____ **First Name** _____ **Relationship:** _____

Home Phone: _____ **Mobile** _____ **Good for one year or until** ____/_____/_____

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

