Calais Dermatology Associates (Minor)

PERSONAL INFORMATION

Name Last: ______________________ First: _______________________ Middle: ________________

DOB: ___________ Age: ______ Sex: _______ Height: _______ Weight: _______ Race: _____________

SS#: ___________________________________

CONTACT INFORMATION

Mailing Address: ____

City/State/Zip: ____

Phone (H): ________________ Mother's cell: _______________ Father's Cell: ____________________

Email Address: _________________________________ Preferred Contact Method: __ Home __Cell __Email

Emergency Contact Name: ____

Number: _______________________________ Relationship: ___________________________________

PCP/ Referring Doctor Name: __________________________ Number: ___________________________

Preferred Pharmacy: ____

RESPONSIBLE PARTY

Name: ______________________________________ Relationship: ______________________________

SS#: ______________________ DOB: ______________________ Email: __________________________

Mailing Address: ____

City, State, Zip: ____

INSURANCE INFORMATION:

Primary Insurance: _________________________ Secondary Insurance: ___________________________

Insurance Address: _________________________ Insurance Address: ____________________________

Name of Insured: __________________________ Name of Insured: ______________________________

Insured's ID #______________________________ Insured's ID #_________________________________

Group # __________________________________ Group # ____________________________________

Patient Release: Must be signed by patient if 18 or over, or by legal guardian if patient is under 18

I certify that that information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I certify that I hereby authorize Calais Dermatology, its providers, and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand additional written consent may be necessary for certain types of procedures and the legal guardian must be present for such consent.

Patient/Guardian Signature: ______________________________________ **Date:** ____________________

History and Intake Form

What is the nature of your visit?

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____

Past Medical History: (Please check all that apply)

__ None
__Anxiety
__Arthritis
__Asthma
__Atrial Fibrillation
__ Bone Marrow
__ BPH
__ Breast Cancer
__ Colon Cancer
__coronary artery disease
__ Depression
__ Diabetes
__ End Stage Renal
__ GERD
__ Hearing Loss
__ Hepatitis
__ High Blood Pressure
__ HIV/Aids
__ High Cholesterol
__ Hyperthyroidism
__ Hypothyroidism
__ Leukemia
__ Lung cancer
__ Lymphoma
__ Radiation Treatment
__ Seizures
__ Stroke

OTHER:

____

Past Surgical History: (Please check all that apply)

__ None
__ Appendix (Appendectomy)
__ Bladder (Cystectomy)
__ Breast: Biopsy
__ Breast: Lumpectomy (Both, Left, Right)
__ Breast: Mastectomy (Both, Left, Right)
__ Colon (Colectomy): Colon Cancer Resection
__ Colon (Colectomy): Diverticulitis
__ Colon (Colectomy): Inflammatory Bowel Disease
__ Colon: Colostomy
__ Gall Bladder (Cholecystectomy)
__ Heart: Biological Valve Replacement
__ Heart: Coronary Artery Bypass Surgery
__ Heart: Mechanical Valve Replacement
__ Heart: PTCA
__ Joint Replacement: Hip (Both, Left, Right)
__ Kidney: Stone Removal
__ Kidney: Transplant
__ Kidney
__ Liver
__ Ovaries: Endometriosis
__ Ovaries: Ovarian Cancer
__ Ovaries: Ovarian Cyst
__ Ovaries: Tubal ligation
__ Pancreas: Pancreatectomy
__ Prostate (Prostatectomy): Biopsy
__Prostate (Prostatectomy): Cancer
__Prostate (Prostatectomy): TURP
__Rectum: (APR)
__ Rectum: Low Anterior Resection
__ Skin: Basal Cell Carcinoma
__ Skin: Squamous Cell Carcinoma
__ Skin: Melanoma
__Skin: Biopsy
__Spleen (Splenectomy)
__ Testicles (Orchiectomy)
__ Hysterectomy

Skin Disease History (please check all that apply including None)

__ None
__ Acne
__ Actinic Keratosis
__ Asthma
__ Basal Cell Carcinoma
__ Blistering Sunburns
__ Dry Skin
__ Eczema
__ Flaking or Itchy Scalp
__Hay Fever/ Allergies
__ Melanoma
__ Poison Ivy
__ Precancerous Moles
__ Psoriasis
__ Squamous Cell Carcinoma

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 (*excluding Basal &Squamous Cell Carcinoma)

If yes, which relative(s): _______________________

Have you received your flu shot this year? ____ Yes ____ No

Have you received a Pneumonia shot in the past? ____ Yes ___ No

Medications: (please enter all current medication and dosage)

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____

Drug Allergies:

____

____

Social History: (Please check all that apply)

Cigarette Smoking:	**Alcohol Use:**
__ Currently smokes	__ None
__ Former smoker	__ Less than 1 drink per day
__ Never smoked	__ 1-2 drinks per day
	__ 3 or more drinks per day

Family Medical History: (Mother, Father, Brother, Sister, or Child) indicate with 1st letter.

Ex. Mother has heart Disease M

___ Heart Disease	____ Diabetes
___ High Blood Pressure	____ Stroke
___ Cancer	____ Other

Anything else we need to know:

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CALAIS DERMATOLOGY ASSOCIATES OFFICE POLICY

Insurance Card Policy: We require you to confirm that your insurance is current at each office visit. New patients or existing patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to provide this documentation, you may pay in full at the time of service and submit the claim to your insurance carrier for reimbursement. **I understand by signing below I am responsible for notifying Calais Dermatology Associates of any changes to my insurance.**

Payment Policy: Co-Payments, Co-Insurance, Deductibles, and all outstanding balances are due and collected on the day of my or my family's appointment.

Account Balances: I am responsible for the timely payment of my account balances, co-insurance, and deductibles. All balances are due in full within 30 days of my first billing. Any balance left unpaid after 90 days, without an attempt at resolution, will be considered delinquent and may be submitted to a collection agency. If I am having financial difficulty, I will call the billing office to discuss a payment plan.

Minor patients: A legal guardian must accompany children under the age of 18 to their initial appointment so that the proper forms can be filled out and signed. Follow up visits do not require a guardian's presence, unless a procedure is being performed that requires a signed consent form.

Appointment Cancellations: If I am unable to keep my scheduled appointment, I will call Calais Dermatology to cancel or reschedule my appointment. Surgical appointments require 48-hour cancellation notice. Regular and Cosmetic appointments require 24-hour cancellation notice. **Deposits for Cosmetic appointments are non-refundable in the event the appointment is not cancelled 24 hours in advance.**

Skin Biopsies: Calais sends all skin biopsies to Sagis Labs. Sagis provides us with comprehensive diagnostic and prognostic information so we can accurately diagnose the disease, prescribe effective therapies, and initiate early treatment options**. If you would like your labs to be sent to a different lab, it is your responsibility to let the nurse know at the time of your visit.**

Patient/ Guardian Signature: __________________________________ **Date:** _____________________

By signing this form, I understand and agree to abide by Calais Dermatology Associates Office Policies on this form.

CALAIS DERMATOLOGY ASSOCIATES HIPAA POLICY

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Calais Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.

Name of Individual (please print)	Relationship to Patient
1.____	_________________________________
2. ____	_________________________________

I understand only the individuals listed above will be provided with information. Should I wish to change or delete any of the names listed above, I will contact Calais Dermatology and request a Patient Update form.

Patient/ Guardian Signature: ____ **Date:** ________________

CALAIS DERMATOLOGY ASSOCIATES NOTICE OF PRIVACY PRACTICES
Patient Acknowledgement

I received and understood Calais Dermatology Associate's Notice of Privacy Practices written in plain language. This notice provides detail on how Medical Information about you may be used and disclosed and how you can get access to this information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Patient/ Guardian Signature: ____ **Date:** ________________