

Calais Dermatology Associates

PERSONAL INFORMATION

Name Last: _____ First: _____ Middle: _____

DOB: _____ Age: _____ Sex: _____ Height: _____ Weight: _____ Race: _____

SS #: _____ Marital Status: _____

CONTACT INFORMATION

Mailing Address: _____

City/State/Zip: _____

Phone (Home): _____ Cell: _____ Work: _____

Email Address: _____ Preferred Contact Method: __ Home __ Cell __ Email

Emergency Contact Name: _____

Number: _____ Relationship: _____

PCP/ Referring Doctor Name: _____ Number: _____

Preferred Pharmacy: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

Insurance Address: _____ Insurance Address: _____

Name of Insured: _____ Name of Insured: _____

Insured's ID # _____ Insured's ID # _____

Group # _____ Group # _____

Employer Name: _____ Employer Name: _____

Relationship of patient to the insured: _____ Relationship of patient to the insured: _____

I authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payments of medical benefits to the provider.

Patient/Guardian Signature: _____ Date: _____

History and Intake Form

What is the nature of your visit?

Past Medical History: (Please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Lung cancer |
| <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Stroke |

OTHER:

Past Surgical History: (Please check all that apply)

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

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

- | | | |
|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever/ Allergies | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Melanoma | |
| <input type="checkbox"/> Blistering Sunburns | | |

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)

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:

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:** _____