CHOICEDERMATOLOGY

Marc Meulener MD, PhD

Patient Information

Name _____ Address _____

(First) (MI) (Last) City/State/Zip_____

Social Security Number _____ Date of Birth _____

Primary Phone_____ (home/cell/work) Secondary Phone _____ (home/cell/work)

E-mail: _____ (Our use only) Contact Method: phone / e-mail / text

Emergency Contact/relationship _____ Phone Number _____

Primary Physician _____Address_____

Phone_____ City/State/Zip_____

Gender ___ Male ___ Female

Race(s) ___ White ___ Black or African American ___ Hispanic ___ Asian ___ Decline to Specify

Insurance Information

Primary Insurance Company _____

Address _____ Phone _____

ID Number _____ Group Number _____

Primary Insured (If Different From Above)

*Responsible Party Name _____ Sex: Male/Female

*Date of Birth_____ Address (if different) _____

Home Phone _____ Cell Phone_____

Relationship to Patient _____

Responsible Party's Employer Company _____ City _____

* required for billing

Do you have additional insurance? If yes, complete the following

Secondary Insurance Company _____ Phone _____

ID Number _____ Group Number _____

Subscriber's Name _____DOB _____ Relationship to patient _____

Medical History (please check all that apply)

___Anxiety
___Arthritis
___Asthma
___Atrial Fibrillation (Irregular Heartbeat)
___BPH (Benign Prostatic Hyperplasia)
___Bone Marrow Transplantation
___Breast Cancer
___Colon Cancer
___COPD
___Coronary Artery Disease
___Depression
___Diabetes
___End Stage Renal Disease
___GERD
___Hearing Loss
___Hepatitis
___Hypertension
___HIV/AIDS
___Hypercholesterolemia
___Hyperthyroidism
_____Hypothyroidism
___Leukemia
___Lung Cancer
___Lymphoma
___Prostate Cancer
___Radiation Treatment
___Seizures
___Stroke

Other _____

Other Medical (Please check all that apply)

___Problems with bleeding
___Problems with healing
___Problems with scarring (keloid)
___Pregnancy or planning pregnancy
___Immunosuppression
___Rapid heartbeat with epinephrine
___Premedication prior to procedure
___Artificial heart valve
___Pacemaker
___Defibrillator

Do you have any other medical history that you would like Dr. Meulener to be aware of?

_____

_____

Surgical History (please check all that apply)

___Appendix Removed
___Bladder Removed
___Breast: Mastectomy (Right, Left, Bilateral)
___Breast: Lumpectomy (Right, Left, Bilateral)
___Breast Biopsy (Right, Left, Bilateral)
___Breast Reduction
___Breast Implants
___Colectomy: Colon Cancer Resection
___Colectomy: Diverticulitis
___Colectomy: Inflammatory Bowel Disease
___Gallbladder Removed
___Heart: Coronary Artery Bypass
___Heart: PTCA (Percutaneous Transluminal Coronary Angioplasty)
___Heart: Mechanical/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
___Kidney Removed (Right, Left)
___Kidney Stone Removal
___Liver: Hepatectomy
___Liver: Transplant
___Liver: Shunt
___Ovaries Removed: Endometriosis
___Ovaries Removed: Cyst
___Ovaries Removed: Ovarian Cancer
___Prostate Removed: Prostate Cancer
___Prostate Biopsy
___Prostate: TURP (Transurethral Resection of Prostate)
___Skin: Skin Biopsy
___Skin: Basal Cell Carcinoma
___Skin: Squamous Cell Carcinoma
___Skin: Melanoma
___Spleen Removed
___Uterus/Hysterectomy: Fibroids
___Uterus/Hysterectomy: Uterine Cancer
___Uterus/Cervical Cancer

Other_____

Patient Name _____ DOB_____ Visit Date_____

Do you have any of the following skin conditions (please check all that apply)

___Acne	___Dry Skin	___Hay Fever/Allergies	___Precancerous Moles
___Actinic Keratosis	___Eczema	___Melanoma	___Psoriasis
___Basal Cell Skin Cancer	___Flaking/ itchy scalp	___Poison Ivy	___Squamous cell skin cancer
___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 If yes, which relative? _____

Medications: all current Prescriptions /Vitamins/Supplements/Herbal Remedies/ OTCs i.e., aspirin, ibuprofen

Medication	Dose	Frequency	Form: *pill, patch*	Medication	Dose	Frequency	Form: *pill, patch*

Vaccinations: Please list the dates (or "do not know") of your most recent vaccinations for:

Influenza:_____ Pneumonia:_____ Tetanus:_____

Allergies to Foods and Medications including Lidocaine and Latex (please specify reactions)

_____

Pharmacy and Location_____

(Please check one)
Alcohol Use: ___No alcohol use
___Less than 1 drink per day
___1-2 drinks per day
___3+ drinks per day

(Please check all that apply)
Tobacco Use: ___Has never smoked
___Currently smokes: Daily? Y / N
___Has smoked in the past
Total number of years smoking _____

Patient Name _____ DOB_____ Visit Date_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES and ELECTRONIC ACCESS

A scanned copy of this authorization shall be considered as valid as the original.
This authorization may be revoked by me in writing.

1. PRIVACY PRACTICES AND RELEASE OF MY PROTECTED HEALTH INFORMATION

I may refuse to sign this acknowledgement.
I have received a copy of Choice Dermatology LLC's Notice of Privacy Practices.
I hereby authorize the Physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier, information needed to determine benefits

2. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. I understand that I am financially responsible for charges not covered by insurance.

3. CANCELLATION POLICY

I understand that if I cancel or change my appointment with less than 24 hours notice, I may be charged $25.00

4. ELECTRONIC MEDICAL RECORD ACCESS

I am aware that I will be assigned a portal for electronic access to my medical record. The practice will provide me a username and password via paper or email.

_____

Signature of Patient or Parent if Patient is a Minor Date

AUTHORIZATION FOR THE RELEASE OF MY MEDICAL INFORMATION TO THIRD PARTY

The following person(s) may receive medical information on my behalf:

_____ _____

Please Print Name(s)/Relationship **Patient's signature**

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____ Individual Refused to Sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other: _____