

DATE: _____

NEW PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)		Social Security Number			
STREET ADDRESS		CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	CELL. PHONE	WHICH IS PREFERRED (H.W.C)?		
MAY WE LEAVE A DETAILED MESSAGE (INCLUDING TEST RESULTS) ON THESE NUMBERS? (CIRCLE ONE) YES / NO					
EMAIL SO WE MAY GIVE YOU ONLINE ACCESS TO YOUR MEDICAL INFORMATION.		SEX	DATE OF BIRTH		
MARITAL STATUS	OCCUPATION				
EMPLOYER	WORK ADDRESS				
IS CONDITION WORK RELATED?					
SPOUSE'S NAME (LAST, FIRST, MI)		SPOUSE'S DATE OF BIRTH			
PRIMARY CARE PHYSICIAN	ADDRESS		PHONE		
HOW DID YOU FIND OUT ABOUT US?					

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME		RELATIONSHIP			
ADDRESS		HOME PHONE			
OCCUPATION	EMPLOYER	WORK PHONE			
I AUTHORIZE COMMONWEALTH DERMATOLOGY, PC TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME TO THE PEOPLE LISTED BELOW					
NAME		NAME			
RELATIONSHIP		RELATIONSHIP			
CONTACT NUMBER		CONTACT NUMBER			

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		NAME OF POLICY HOLDER			
GROUP #	CERTIFICATE / POLICY/ ID#		POLICY HOLDERS DATE OF BIRTH		
MEDICARE#	MEDICAID #		POLICY HOLDERS SOCIAL SECURITY NUMBER		
SECONDARY INSURANCE COMPANY		NAME OF POLICY HOLDER		POLICY HOLDERS SOCIAL SECURITY NUMBER	
GROUP #	CERTIFICATE / POLICY/ ID#		POLICY HOLDERS DATE OF BIRTH		

Patient Name: _____ DOB: _____

Statement of Patient Financial Responsibility

Commonwealth Dermatology appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Commonwealth Dermatology, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to The Practice Name, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient consent for use and disclosure of protected health information

With my consent, Commonwealth Dermatology, may use and disclose protected health information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to Commonwealth Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures. Commonwealth Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to Commonwealth Dermatology, 3055 Washington Road Suite 203, McMurray, PA 15317.

Consent for Treatment and Authorization to Release and Receive Information

I hereby authorize Commonwealth Dermatology, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Commonwealth Dermatology, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I authorize Commonwealth Dermatology to send and receive information with my pharmacy, including my prescription fill history. This information is used to ensure we have an up to date medication history and to prevent medication interactions.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. If you no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, you may be discharged from care. The Practice will notify you in writing, via certified mail, if you are discharged from care.

Patient Portal

You can now access your medical information using our patient portal: update your chart, receive test results, and send us messages. By providing us with your email address, you are giving us consent to activate your online portal.

Acceptance of the Above Policies

By signing below, I am consenting to the statement of financial responsibility, consent for treatment and authorization to release information, cancellation / no show policy, and indicating my preference on patient portal use.

Patient/Guarantor Signature _____ Date _____

History and Intake Form

Medication allergies: _____

Current medications: (Please write below or give us your written list)

Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____

Pharmacy name: _____ **Pharmacy phone number:** _____

Who is your primary doctor? _____ **How did you hear about us?** _____

What is the reason for today's visit: _____

Past Medical History: (please circle all that apply)

- | | | |
|-------------------------|---------------------------|---------------------|
| Anxiety | Depression | Hypothyroidism |
| Arthritis | Diabetes | Leukemia |
| Asthma | End Stage Renal Disease | Lung cancer |
| Atrial fibrillation | GERD (acid reflux) | Lymphoma |
| Bone Marrow transplant | Hearing Loss | Prostate cancer |
| Prostate enlargement | Hepatitis (liver disease) | Radiation treatment |
| Breast Cancer | High blood pressure | Seizures |
| Colon Cancer | HIV/AIDS | Stroke |
| COPD | High cholesterol | |
| Coronary Artery Disease | Hyperthyroidism | NONE |

Other _____

Past Surgical History: (please circle all that apply)

- | | | |
|---------------------------------|---------------------------------|-------------------------------|
| Appendix removed | Knee Replacement (L, R, Both) | Prostate biopsy |
| Bladder removed | Kidney Biopsy | Prostate removal: cancer |
| Breast: biopsy | Kidney stone removal | Prostate removal: TURP |
| Breast: Lumpectomy (L, R, Both) | Kidney removal | Rectum: resection |
| Breast: Mastectomy (L, R, Both) | Liver partial removal | Skin: Basal cell carcinoma |
| Colon removal | Liver transplant | Skin: melanoma |
| Colostomy bag | Liver shunt | Skin: skin biopsy |
| Gallbladder removal | Ovary removal for endometriosis | Skin: squamous cell carcinoma |
| Heart valve replacement (pig) | Ovary removal for cancer | Spleen removal |
| Heart valve replacement (metal) | Ovary removal for cyst | Testicle removal |
| Heart: catheterization | Tubal ligation | Hysterectomy |
| Hip Replacement (L, R, Both) | Pancreas partial removal | NONE |

Other _____

Skin Disease History: (Please circle any that apply)

Acne	Eczema	Precancerous moles
Actinic keratosis (pre-cancers)	Flaking or itchy scalp	Psoriasis
Asthma	Hay fever / allergies	Squamous cell skin cancer
Basal cell skin cancer	Melanoma	Other: _____
Blistering sunburns	Poison Ivy	_____

Social History: (Please circle all that apply)

Smoking history:	Alcohol Use:	Do you wear sunscreen? Yes No
Currently smoke	None	If Yes, what SPF _____
If yes, how many / day _____	Less than 1 drink per day	Do use a tanning salon? Yes No
Has smoked in the past	1-2 drinks per day	
Never smoker	3 or more drinks per day	

How many times in the past year have you had 4 or more drinks in a day? _____

Did you get a flu vaccine this season? Yes / No Have you ever received the pneumonia vaccine: Yes / No

Occupation: _____ **Hobbies:** _____

Family History (Please circle all that apply)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Non Melanoma Skin Cancer	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Acne	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Arthritis	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Asthma	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Eczema	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Hay Fever/Allergies	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Lupus	Mother	Father	Sister	Brother	Daughter	Son	Other _____
Psoriasis	Mother	Father	Sister	Brother	Daughter	Son	Other _____

Review of Systems: Do any of these currently apply? (Please circle Yes / No)

Changing mole	Yes / No	Abdominal pain	Yes / No	Pacemaker	Yes / No
Rash	Yes / No	Bloody stool	Yes / No	Defibrillator	Yes / No
Problems with healing	Yes / No	Bloody urine	Yes / No	Artificial heart valve	Yes / No
Problems with scarring	Yes / No	Joint aches	Yes / No	Artificial joint	Yes / No
Fevers / chills	Yes / No	Muscle weakness	Yes / No	Joint replacement last 2 years	Yes / No
Night sweats	Yes / No	Neck stiffness	Yes / No	Premedication before surgery	Yes / No
Unintended weight loss	Yes / No	Headaches	Yes / No	Blood thinners	Yes / No
Problems with bleeding	Yes / No	Seizures	Yes / No	Hepatitis B or C	Yes / No
Immunosuppression	Yes / No	Cough	Yes / No	HIV / AIDS	Yes / No
Hay fever	Yes / No	Shortness of breath	Yes / No	Allergy to lidocaine	Yes / No
Chest pain	Yes / No	Wheezing	Yes / No	Heart racing with epinephrine	Yes / No
Thyroid problems	Yes / No	Anxiety	Yes / No	Adhesive allergy	Yes / No
Sore throat	Yes / No	Depression	Yes / No	Topical antibiotic allergy	Yes / No
Blurry vision	Yes / No	Latex allergy	Yes / No	MRSA	Yes / No
				Pregnant or planning to be	Yes / No