History and Intake Form

Patient Name: _____ **DOB:** _____ / _____ / _____

Preferred Language: _____ **Race:** _____

Ethnic Group ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ I choose not to specify

Pharmacy (name/town/phone #): _____

Reason for todays visit:

_____

_____

Past Medical History: (please circle all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Head Trauma
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

Other:

Past Surgical History: (please circle all that apply)

- Appendix Removed
- Bladder Removed
- Breast Biopsy (right, left, bilateral)
- Lumpectomy (right, left, bilateral)
- Mastectomy (right, left, bilateral)
- Colectomy
- Colostomy
- Gallbladder Removed
- Coronary Artery Bypass
- Angioplasty (PTCA)
- Biological Valve Replacement
- Mechanical Valve Replacement
- Heart Transplant
- Hip Replacement (right, left, bilateral)
- Knee Replacement (right, left, bilateral)
- Kidney Biopsy
- Kidney Removed (right, left)
- Kidney Stone Removal
- Kidney Transplant
- Hepatectomy
- Liver Transplant
- Liver Shunt
- Ovaries Removed (endometriosis, cancer, cyst)
- Tubal Ligation
- Pancreas Removed
- Prostate Removed (cancer, TURP)
- Rectal Resection
- Spleen Removed
- Testicles Removed (right, left, bilateral)
- Hysterectomy (fibroids, uterine cancer, cervical cancer)

Other:

Skin Disease History: (please circle all that apply)

- Acne
- Actinic Keratosis
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking/Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

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 MALIGNANT MELANOMA?

☐ YES ☐ NO

If yes, which relative (s): _____

MEDICATIONS (please list all current medications):

_____ _____

_____ _____

_____ _____

_____ _____

☐ NO MEDICATIONS

DRUG ALLERGIES (please list all known allergies and reactions):

_____ _____

_____ _____

☐ NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY:

Smoking Status: ☐ Current every day smoker ☐ Current someday smoker
☐ Former smoker ☐ Never smoker

Alcohol Use: ☐ None ☐ < 1 drink per day ☐ 3 or more drinks per day

Occupation: _____

ALERTS: (please circle all that apply)

• **Allergy to adhesive**	• **Artificial joint replacement**	• **MRSA**
• **Allergy to latex**	• **Blood thinners**	• **Pacemaker**
• **Allergy to lidocaine**	• **Defibrillator**	• **Require antibiotics prior to procedure**
• **Artificial valve replacement**	• **Keloid scarring**	• **Rapid heart beat with epinephrine**

ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		

Completed by: ☐ Patient
☐ Medical Assistant _____ Initials

_____ ____/____/____
Signed by Patient Date

_____ ____/____/____
Reviewed by Date

PLYMOUTH DERMATOLOGY ASSOCIATES, P.C.

PATIENT INFORMATION SHEET

NAME: _____ **BIRTH DATE:** _____
FIRST M. I. LAST

CIRCLE ONE: Single Married Widowed Divorced

MAILING Address: _____
STREET # OR PO BOX TOWN STATE, ZIP CODE

HOME PHONE: _____ **CELL Phone:** _____

PATIENT E-MAIL: _____

PRIMARY CARE DOCTOR: _____ **TELEPHONE** _____

INSURANCE NAME: _____ **SUBSCRIBER NO.** _____

FINANCIALLY RESPONSIBLE PARTY FOR INSURANCE: _____

RESPONSIBLE PARTY FOR A MINOR CHILD: _____

ADDRESS IF DIFFERENT FROM PATIENT: _____

TELEPHONE IF DIFFERENT FROM PATIENT: _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS. I AUTHORIZE PAYMETS OF MEDICAL BENEFITS TO PLYMOUTH DERMATOLOGY ASSOCIATES, P.C. FOR SERVICES PROVIDED. I AUTHORIZE TREATMENT OF MY SON/DAUGHTER. This information is accurate and true to the best of my knowledge. I understand I am responsible to pay for services rendered, including fees and cost of collections in the event of default.

SIGN NAME OF PATIENT/PARENT: _____ **DATE:** _____

COSMETIC INTEREST QUESTIONNAIRE

PLEASE CIRCLE ANY OF THE FOLLOWING ISSUES YOU WOULD LIKE TO RECEIVE MORE INFORMATION ON.

Fine Lines and Wrinkles
Eyelashes: Wish to be Longer, Fuller, Darker
Overall Skin Rejuvenation / Skin Care Advise
Age Spots/ Facial Pigmentation Problems
Facial Fillers
Medical Skin Care Products/Retinol
Laser Hair Removal
Botox

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Plymouth Dermatology
ASSOCIATES PC

I am a patient of Plymouth Dermatology Associates, PC. I hereby acknowledge receipt of Plymouth Dermatology Associated PC's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ (patient name). I hereby acknowledge receipt of Plymouth Dermatology Associated PC's Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

Plymouth Dermatology
ASSOCIATES PC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health Information and how we may disclose your personal information.

We may use and disclose your medical record only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-indentified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fund raising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fund raising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operation;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of **September 18, 2013** and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Anne-Sophie Gadenne, MD, 508-746-5300 for more information, in person or in writing.