

Patient Information Record
Please PRINT All Information

PATIENT ACCOUNT NO.

DATE

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MI)				SOCIAL SECURITY NUMBER	
STREET ADDRESS		CITY		STATE	ZIP
HOME PHONE		WORK PHONE		CELL or ALTERNATE PHONE	
EMAIL ADDRESS:					
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARTIAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed	AGE	DATE OF BIRTH	HAVE YOU EVER BEEN A PATIENT IN THIS OFFICE BEFORE <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, WHEN?	
OCCUPATION			EMPLOYER		
WORK ADDRESS					
SPOUSES NAME (LAST, FIRST, MI)				SPOUSES DATE OF BIRTH	
STUDENT STATUS Full Time Part Time Not a Student		PRIMARY CARE PHYSICIAN		ADDRESS	PHONE

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME		RELATIONSHIP	
ADDRESS			
OCCUPATION		EMPLOYER	PHONE
ADDRESS		WORK PHONE	

POLICY HOLDER INFORMATION

<i>PRIMARY INSURANCE INFORMATION</i>		
INSURANCE COMPANY		NAME OF POLICY HOLDER
GROUP #	CERTIFICATE/POLICY/ ID#	POLICY HOLDERS DATE OF BIRTH
MEDICARE #	MEDICAID #	POLICY HOLDER'S SOCIAL SECURITY NUMBER

<i>SECONDARY INSURANCE INFORMATION</i>		
INSURANCE COMPANY		NAME OF POLICY HOLDER
GROUP #	CERTIFICATE / POLICY / ID #	POLICY HOLDERS DATE OF BIRTH

Assignment of Benefits:

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/ or all commercial payors to make payments on my behalf directly to Anne Arundel Dermatology. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

Signed _____

Date _____

***A fee may be incurred for No Show and/or cancellation without required notice. Initial _____ Date _____ ***

How did you hear about Anne Arundel Dermatology, P.A. and Affiliate Practices

Radio Insurance Website Magazine Google Search Social Media Family/Friend Physician Referral Other: _____

Patient Name: _____

Date of Birth: _____

General Consent/Agreement to Outpatient Services

This form applies to all Anne Arundel Dermatology practice sites. This form must be completed by all new patients and then, at least annually or when the patient's insurance changes.

1. **CONSENT TO TREATMENT:** I consent to receive medical and/or cosmetic health care services provided by Anne Arundel Dermatology (AADerm") entities. I understand that such services may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.
2. **PAYMENT FOR SERVICES:** I understand that AADerm may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Anne Arundel Dermatology . If I should receive the payments, I understand that I will be responsible for paying AADerm. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. I understand that AADerm will hold me responsible in any one of the following situations
 - a. When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
 - b. When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
 - c. When my health plan does not participate with AADerm for the services I want or need and I agree to pay for my care myself.
 - d. When I receive services that are not covered under my health plan including cosmetic services.

If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have AADerm act on my behalf to obtain my benefits when AADerm asks to do so. I also agree that AADerm can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

I understand if I do not show up for a scheduled visit and do not notify the office, I will pay a NO SHOW fee of \$50.00. If I cancel my appointment in advance or on the day I am scheduled, my appointment will be rescheduled without a fee. If I repeatedly cancel, a cancellation fee may be charged.

3. **CONSENT TO PHOTOGRAPH:** I understand photographs, videotapes, digital and/or other images may be made/recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.
4. **ELECTRONIC PRESCRIBING:** I authorize SureScripts, an electronic prescribing network, to release my medication refill history to AADerm for the purpose of continued treatment.
5. **MY PERSONAL BELONGINGS:** I understand that I am responsible for my personal belongings and valuables.
6. **RELEASE OF INFORMATION:** I authorize AADerm practice site(s) to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information from or regarding prior encounter(s) at other AADerm practice locations may be made available to subsequent AADerm-affiliated sites to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES to FAMILY and FRIENDS: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

7. COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT: I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for AADerm and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of AADerm. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

You may be contacted via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

Home Phone: _____ Cell Phone: _____

Authorized email address: _____

OR

(Initials) I decline to receive communication via text.

(Initials) I decline to receive communication via email.

Revocation

I hereby revoke my request for future communications via email and/or text.

I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via text

I hereby revoke my request to receive any future appointment reminders, feedback, marketing, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

8. NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received/reviewed AADerm's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I agree to the items as outlined in the Agreement.

Name (Print): _____ Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative): _____



Date: _____ DOB: _____ MRN: _____

Patient Name: _____

Referring Provider: _____

MEDICATION ALLERGIES: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

MEDICAL HISTORY AND INTAKE FORM

Past Medical History: (Please circle all that apply)

- | | | |
|----------------------------------|----------------------------------------|----------------------------------------|
| None | Elevated blood pressure | Malignant Lymphoma |
| Anxiety disorder | End-stage renal disease | Malignant tumor of lung |
| Arthritis | Epilepsy | Malignant tumor of breast |
| Asthma | Gastroesophageal reflux disease | Malignant tumor of colon |
| Atrial Fibrillation | H/O: hypertension | Malignant tumor of prostate |
| Benign prostatic hyperplasia | Hearing loss | Radiation therapy treatment management |
| Cerebrovascular accident | Human immunodeficiency virus infection | Transplantation of bone marrow |
| Chronic obstructive lung disease | Hypercholesterolemia | Other: _____ |
| Coronary arteriosclerosis | Hyperthyroidism | _____ |
| Depressive disorder | Hypothyroidism | _____ |
| Diabetes mellitus | Inflammatory disease of liver | _____ |
| Disease caused by 2019-nCoV | Leukemia | _____ |

Have You Had Surgery On Any Of The Following Organs: (Please circle all that apply)

- | | | |
|-----------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------|
| None | History of tissue graft heart valve replacement | Splenectomy |
| Abdominoperineal resection | History of total cystectomy | Surgical biopsy of skin |
| Bilateral replacement of knee joints | History of transurethral prostatectomy | Total nephrectomy |
| Biopsy of breast | Hysterectomy | Total orchidectomy |
| Biopsy of prostate | Kidney biopsy | Total replacement of left hip joint |
| Coronary artery bypass graft | Low anterior resection of rectum | Total replacement of left knee joint |
| Entire transplanted kidney | Lumpectomy of breast | Total replacement of right hip joint |
| Excision of basal cell carcinoma | Lumpectomy of left breast | Total replacement of right knee joint |
| Excision of melanoma | Lumpectomy of right breast | Transplantation of heart |
| Excision of squamous cell carcinoma | Mastectomy of left breast | Transplantation of liver |
| H/O: colostomy | Mastectomy of right breast | Other: _____ |
| H/O: tubal ligation | Mechanical heart valve replacement | _____ |
| History of appendectomy | Oophorectomy | _____ |
| History of bilateral mastectomy | Pancreatectomy | _____ |
| History of cholecystectomy | Percutaneous extraction of kidney stone with fragmentation procedure | |
| History of colectomy | Portosystemic shunt operation | |
| History of liver excision | Prostatectomy | |
| History of percutaneous transluminal coronary angioplasty | Prosthetic arthroplasty of bilateral hips | |

OTHER: _____

Immunizations: Have you had the following immunizations?

Vaccine: _____ **Date of Vaccination (can be approximate if unsure):** _____

Influenza (Flu) _____

Pneumonia _____

Varicella (Shingles) _____

Skin Disease History: (please circle all that apply)

None	Dysplastic nevus of skin	Psoriasis
Acne	Eczema	Squamous cell carcinoma
Actinic Keratosis	H/O: asthma	Sunburn of second degree
Asteatosis cutis	H/O: hay fever	Other: _____
Basal cell carcinoma of skin	Malignant melanoma	_____
Contact dermatitis due to poison ivy	Pruritis of scalp	

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**? If yes, which relative(s)? _____

Social History:

Smoking Status: (Please circle one)

Current every day smoker
Current some day smoker: Tobacco
Current some day smoker: Cigarettes
Former Smoker

Never Smoker

Smoker: Current status unknown
Unknown if ever smoked
Heavy tobacco smoker
Light tobacco smoker

Alcohol Status: (Please circle one)

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Occupation: _____

Hobbies: _____

Family History:(please check all that apply)

Acne	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Arthritis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Eczema	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Hay Fever/Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Lupus	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Psoriasis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Non-Melanoma Skin Cancers	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None

Review of Systems: Do you have or are you currently experiencing any of the following? (Please circle Yes "Y" or No "N")

Changing Mole	Y N	Immunosuppression	Y N	Allergy to LATEX	Y N
Rash	Y N	Hay fever/seasonal allergies	Y N	Allergy to chlorhexidine	Y N
Itching	Y N	Food allergies	Y N	Allergy to lidocaine	Y N
Hair loss	Y N	Sore throat	Y N	Increased heart rate with epinephrine	Y N
Acneiform lesions	Y N	Cold sores	Y N	Lightheaded or fainting with procedures	Y N
Problems with healing	Y N	Visual changes	Y N	Allergy to topical antibiotic ointment	Y N
Problems with scarring (hypertrophic or keloidal)	Y N	Eye irritation	Y N	GI upset with antibiotics	Y N
		Headaches	Y N	Artificial heart valve	Y N
Fever or chills	Y N	Seizures	Y N	Artificial joint within last two years	Y N
Night sweats	Y N	Depression	Y N	Premedication prior to procedures	Y N
Fatigue	Y N	Anxiety	Y N	Blood thinners	Y N
Unintentional weight loss	Y N	Change in mood	Y N	Defibrillator	Y N
Joint pains	Y N	Breast tenderness	Y N	Pacemaker	Y N
Muscle aches	Y N	Menstrual irregularities	Y N	History of MRSA	Y N
Muscle weakness	Y N	Thyroid problems	Y N	Hepatitis	Y N
Problems with bleeding	Y N	Abdominal pain	Y N	HIV/AIDS	Y N
History of clotting disorder/Increased clotting	Y N	Nausea	Y N	Pregnancy or planning a pregnancy	Y N
Nose bleeds	Y N	Vomiting	Y N	Currently breastfeeding	Y N
Cough	Y N	Diarrhea	Y N		
Wheezing	Y N	Bloody stool	Y N		
History of Latent TB	Y N	Allergy to adhesive	Y N		

Medications:

Please list all current medications including prescriptions, over-the-counter medications, vitamins, minerals and supplements. **If not currently on medications, write NONE or N/A.**

Please check box and do not fill out medication list if you have been seen in the last 6 months **AND** you gave us your medication list at that time **AND** your medication list has not changed.

Name of Prescribed Medication	Dose	Route	Frequency
Example: Lipitor 20 mg	1 tablet	Orally	Once a day

Over the Counter Medication	Dose	Route	Frequency
Example: Fish Oil 1000 mg	1 tablet	Orally	Once a day

Patient Name: _____

DOB: _____

MIPS Questionnaire

Today's Date: _____

Patient Questionnaire

1. Are you a tobacco **smoker**? **Current / Former / Never**
(Please circle answer)

2. Have you received an Influenza Vaccine during flu season (August 2019-March 2020 or August 2020-March 2021)? **Yes / No**

If **NO**, select reason why: **Refused / Allergy**

For Patients 65 years and older

3. Have you ever had a Pneumonia Vaccine (Pneumovax 23 and/or Prevnar 13)?
Yes / No (Please circle answer)

4. Do you have a health care proxy in the event you are unable to make your own medical decisions? **Yes / No** (Please circle answer)

5. Do you have a living will? **Yes / No** (Please circle answer)

6. Which statement(s) best reflects your wishes on advanced care recommendations? (Please check all that apply)

- Do Not Intubate:** I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation efforts to be made.

Patient Name: _____ DOB: _____

Primary Care Physician: _____

Patient Portal Access

Please Share your email address with us so you can access these great features:

- Communicate with your provider via email
- View your visit notes
- Update your medication list
- Update your medical history
- View patient education materials
- Add your favorite pharmacy for electronic Rx

*Within 24 hours you will receive an email stating “A request was made to activate your patient portal with Anne Arundel Dermatology and Affiliate Practices”

*Please follow the links in the email to set up your patient portal. The link will expire in exactly 24 hours after receiving the email. Please contact our office if your link expires before you activate your account.

**The email will come from Modernizing Medicine which is our electronic medical software*

Patient Portal Consent

Last Name: _____ First Name: _____

Date of Birth: ____ / ____ / ____ Email Address: _____

Please do not send me occasional announcements and offers from Anne Arundel Dermatology

Please check if you wish to decline the patient portal.

Signature: _____ Date: ____ / ____ / ____