River Ridge Dermatology

Patient Name: _____ Date of Birth: _____ / _____ / _____
Primary Care Physician:_____ Referring Physician_____

History and Intake Form

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ None

Other:

_____

Do you wear Sunscreen? ○ Yes ○ No **Preferred Pharmacy:**_____
If yes, what SPF? _____
Do you tan in a tanning salon? ○ Yes ○ No **Location:**_____

Do you have a family history of Melanoma? ○ Yes ○ No
If yes, which relative(s)? _____

Medications: (Please list all current medications)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you take any type of blood thinner? ○ Yes ○ No
Do you take aspirin daily? ○ Yes ○ No

Allergies: (Please list all allergies)

_____ _____ _____
_____ _____ _____

Are you allergic to Latex? ○ Yes ○ No
Are you allergic to Iodine or Betadine? ○ Yes ○ No

Social History: (Please check all that apply)

- ☐ Smoker
- ☐ Former Smoker
- ☐ Received the flu vaccine within the last year
- ☐ Received the pneumonia vaccine within the last 5 years
- ☐ Drink Alcoholic Beverages
  If checked, how many per week? _____

Height_____ Weight_____

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History and Intake Form (cont.)

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ 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
- ☐ Pacemaker/Defibrillator
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None

Other:_____

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ 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
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

Other:_____

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Review of Systems:

Do you have any of the following?

- ☐ A pacemaker
- ☐ A defibrillator
- ☐ Artificial joints that were replaced within the past 2 years
- ☐ Artificial heart valve
- ☐ Require premedication prior to procedures
- ☐ An allergy to adhesive
- ☐ An allergy to topical antibiotic ointments
- ☐ Take any type of blood thinner
- ☐ Pregnant or planning to get pregnant
- ☐ An allergy to lidocaine
- ☐ Experience a rapid heartbeat with epinephrine
- ☐ Experience yeast infections when taking antibiotics
- ☐ Experience G.I. upset with antibiotics

Are you ***currently experiencing*** any of the following?

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Have any concern with immunosuppression
- ☐ A changing mole
- ☐ A rash (diagnosed or undiagnosed)
- ☐ Abdominal pain
- ☐ Anxiety
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Chest Pain
- ☐ A cough
- ☐ Depression
- ☐ Fever or chills
- ☐ Headaches
- ☐ Hay fever
- ☐ Joint Aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Night sweats
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Thyroid problems
- ☐ Unintentional weight loss
- ☐ Wheezing

What is the main reason for your visit today? _____

Patient Information Form

Date: _____/_____/_____

RIVER RIDGE DERMATOLOGY

Name: _____ ☐ Married ☐ Single ☐ Widowed
FIRST MIDDLE LAST

Mailing Address: _____ Home Phone: (____)_____-_____

Street Address: _____ Work Phone: (____)_____-_____

City: _____ State: _____ Zip:_____ Mobile Phone (____)_____-_____

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

Social Security #: _____ Employment Status/Employer: _____

How did you hear about us? _____ Language: ☐ English ☐ Spanish ☐ Other:_____

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Not Hispanic or Not Latino ☐ Hispanic or Latino ☐ Other:_____

Race: ☐ Asian ☐ Black African American ☐ White

Referring Physician_____ Phone Number: (____)_____-_____

Insurance Information

Policy Holder (Primary Name on Insurance Card): _____ Relationship to Patient:_____

Policy Holder Address (if different from patient): _____

Phone #: (_____)_____-_____ Date of Birth: ____/____/_____

Person Responsible for payment: _____

Address of Person Responsible for payment: _____

I hereby authorize River Ridge Dermatology to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed above. I authorize payment for these services to be made directly to River Ridge Dermatology**. I also understand that I am responsible for payment of services not covered by my insurance company and that payment for co-pays are required at the time of service.**

Signature of Responsible Party_____ Date:_____/_____/_____

Printed name: _____

Emergency Contact Information

Name: _____ **Phone Number:** _____

Address: _____ **Relationship**: _____

Authorization to Release Information:

May we leave messages regarding future appointments on your voice mail or email? ○ **Yes** ○ **No**
May we leave biopsy or test results on a voice mail? ○ **Yes** ○ **No**
May we leave messages/send emails regarding cosmetic events/promos. ○ **Yes** ○ **No**

I authorize River Ridge Dermatology to discuss my care and/or appointments with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Welcome to River Ridge Dermatology. Our goal is to provide you with the best possible care in a comfortable, friendly environment. In order to minimize the possibility of any miscommunication or misunderstandings we ask that you review the following office policies and indicate your understanding and agreement. If you would like any further clarification, our staff will be happy to assist you. Welcome to the River Ridge Family.

No Show/Cancellation/Late Policies

In order to reduce wait time for our patients, we ask that you arrive 5-10 minutes early for your appointment. In addition, your appointment time is reserved specifically for you and in the event that you are unable to keep your appointment, we request enough time to make that appointment slot available to patients that are waiting to be seen. Please review the following policies that apply to all patients and all circumstances.

Late Policy: Appointments will be rescheduled if you are more than 15 minutes late for your scheduled appointment time.

Cancellation Policy: Appointments must be cancelled at least one full business day prior to your scheduled appointment time. Failure to do so will result in the following non-insurance fees being charged to your account:

No show fee for Office Visit: $50 - No show fee for Cosmetic Procedures/Surgery: $150

Payment Policies:

- In order to keep our costs and fees as low as possible we ask that all Co-Pays and Coinsurance amounts be paid at the time of service. River Ridge Dermatology will file your insurance claim on your behalf. Once payment is received from your insurance company, we will send you a statement detailing any refund or balance owed.
- It is the patient's responsibility to know if their provider is participating with their medical plan network. If we are not a participating provider your insurance company may not pay for some or all of the charges associated with your visit. Any remaining charges not paid by the insurance company will be the patient's responsibility.
- **If your insurance requires a referral, it is the patient's responsibility to ensure that we have received the referral prior to their scheduled appointment. If we have not received your referral prior to your appointment you will be responsible for the full amount of any charges that are not covered by your insurance.**
- Failure to pay in a timely manner will result in your balance being forwarded to a collection agency in which a fee will be assessed to your bill.
- I authorize the provider or its agents to call my cell phone number either manually or by auto-dialer in order to collect any amount I owe. I also authorize the provider or its agents to contact me via email or by any other means of contact listed on this form to collect any amount I owe.

Consent for HIV, Hepatitis B or C Testing:

I agree and consent to the withdrawal and testing of my blood, without further consent by me, in the event that there is an accidental blood borne pathogen exposure to any medical, nursing or other clinical staff, in order to test such blood for the presence of Hepatitis B virus or HBV, Hepatitis C virus or HCV, and Human Immunodeficiency Virus of HIV. I understand and agree that the results of such laboratory testing shall be maintained confidential, except to my treating healthcare providers, any clinical staff so exposed, and as may be allowed by any applicable state or federal statute, regulation or rule of law.

I have read and understand the above policies. I have had the opportunity to review the Privacy Practices for River Ridge Dermatology and consent to be bound by those policies.

Signed: _____ Date: _____/_____/_____