Dermatology & Plastic Surgery of Arizona

Christopher W. Weyer, D.O., F.A.O.C.D. Jamie M. Moenster, D.O., F.A.C.O.S Molly Daneker, FNP-C

** Please fill out **all** sections completely **

Full Name: _____ Gender: _____ Marital Status: _____

Address: _____City:_____State: _____Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #:_____

Employer: _____Occupation: _____

Race: _____ Ethnicity: _____ Preferred language: _____

E-mail: _____Preferred method of contact: _____

May we communicate via e-mail? _____ May we leave a message with others? _____

May we leave a message on your voicemail? _____ Is it ok to send postcard reminders? _____

Primary Care Physician: _____Phone: (__) _____

Emergency Contact: _____Relationship:_____ Phone: (____) _____

Do you have a Living Will or a Power of Attorney? _____

Policy Holder's Name: _____

Date of birth: _____Social Security #:_____Gender: _____

Address (If different from patient):_____

Relationship to patient: _____ Employer: _____

Primary Insurance: _____ Name on Contract: _____

Group or ID #: _____ Policy #:_____

Secondary Insurance: _____ Name on Contract: _____

Group or ID #: _____ Policy #:_____

Tertiary Insurance: _____ Name on Contract: _____

Group or ID #: _____ Policy #:_____

How did you hear about our practice? _____

Example: friend, doctor referral, internet search, insurance company, advertisement, website, phone book, other

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AUTHORIZATION: I hereby authorize Dermatology and Plastic Surgery of Arizona (DPSAZ) to administer treatment and perform procedures as necessary or advisable in the diagnosis and treatment of this illness/injury. In addition I hereby authorize and assign DPSAZ to furnish information to insurance carriers concerning the illness/injury, including if necessary, photographs, and I hereby authorize and assign DPSAZ all the payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as avid as the original.

Signature: _____ Date: _____

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Patient's Full Name: _____

Today's Date: _____ Date of Birth: _____ Age: _____ Gender: _____

Reason for your visit: _____

1. Medical History

Please mark all conditions that you currently have or have had in the past:

___Anxiety
___Arthritis
___Asthma, breathing problems
___Bleeding disorder
___Blood clots (DVT, PE)
___ Breast cancer
___Cancer
___Chest pain/tightness
___Cold sores/herpes type 1
___Depression
___Diabetes
___Headaches/Migraines
___Heart disease
___Heart Murmur
___Hepatitis/liver disease
___High blood pressure
___HIV/AIDS
___Hives
___Implanted joints or medical devices
___Kidney disease
___Seizures
___Stroke/mini-stroke
___Thyroid disorder
___Tuberculosis
___Ulcers
___Unlisted medical issue
___X-ray therapy
___None

2. Surgical History: (list all surgeries, dates, hospital and surgeon. If none, please write "none".)

_____
_____
_____
_____
_____

2a. Any problems with Anesthesia in the past? (If yes, please specify what type)

_____

3. Past Skin History

___Actinic Keratosis
___Basal Cell Carcinoma
___Eczema
___History of Blistering Sunburn
___Hyper or Hypo-Pigmentation
___Malignant Melanoma
___Other Skin Issue
___Psoriasis
___Rash
___Scarring (Keloid or Hypertrophic)/Abnormal Healing
___Squamous Cell Carcinoma
___Tanning Bed use
___None

4. Family History- PLEASE LIST AFFECTED FAMILY MEMBER & IF THEY ARE MATERNAL OR PATERNAL

___Abnormal bleeding_____
___Blood clots (DVT)_____
___Adopted_____
___Autoimmune Disorder_____
___Brain Tumor_____
___Breast Cancer_____
___Diabetes_____
___Endocrine disorder_____
___Heart disease_____
___Hemophilia_____
___High blood pressure_____
___Kidney disease_____

Patient's Full Name: _____Date of Birth: _____

Family History continued

___Liver disease_____
___Lung Cancer_____
___Malignant Melanoma_____
___Other Cancer_____
___Ovarian Cancer_____
___Prostate Cancer_____
___Skin Cancer_____
___Skin Disease_____
___Stroke/mini-stroke_____
___von Willebrand_____
___None

5. Allergies:

Type (Name of medicine, seasonal, latex and adhesives. If none, please write "none".) Reaction to allergen

_____
_____
_____
_____

6. Current Medications : (Include prescription, over the counter, herbals and vitamins. If none, please write "none".)

Name Dose Frequency Reason for taking

_____
_____
_____
_____
_____
_____
_____
_____
_____

7. Social History

Do you drink alcohol, even on occasion? _____
How often? _____ What type? _____

Do you smoke now or Have you ever smoked or Do you use other forms of nicotine? _____
How much per day? _____ If you are a former nicotine user, when did you quit? _____

Do you use recreation or illicit drugs? _____ Which ones and how often? _____

Height_____ Weight _____ Do you exercise? What kind and how often? _____

What are your interests or hobbies? _____

Occupation: _____ Former Occupations: _____

8. Is there anything else about your health or your visit that would be important for us to know?

_____

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Patient's Full Name: _____Date of Birth: _____

Privacy Consent

This consent is required by the Health Insurance portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for Care: I, with my signature, authorize this practice, and any employee working under the direction of the physician, to provide medical services for me, or to this patient in which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information: I also authorize this practice to furnish information to the identified insurance carriers for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent for Assignment of Benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information for my health plan about service coverage. If I seek care outside of the contract, I am aware that **I** may be responsible for all charges that are incurred.

I understand that there is a $50 charge for a returned check, which is only payable by cash or money order. This will be applied to my account in addition to the insufficient funds amount, and I may be placed on a cash only basis following any returned check.

Consent Related to Privacy Notice: I have been given a copy of practice privacy notice as part of this registration process. I understand that the terms of the privacy notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Please list the names of all family and/or friends for us to be able to speak with regarding your medical and / or financial information (e.g. pathology results, appointments, billing, etc.)

Name	Relationship	Phone number
Name	Relationship	Phone number

Signature of Patient/Guardian:_____ Date:_____

Witness Initials / Signature: _____ __

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Cosmetic Questionnaire

Patient Name: _____

Date:_____

What is the reason for your visit today? _____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

oSkin care advice/products
oLength/fullness of eyelashes
oBotox/Juvederm injections
oThin lips
oBlotchy skin
oChemical Peels
oMake up
oFacial veins/redness
oBrown spots/age spots/freckles
oDrooping eyelid
oNose size or shape
oMole/lesion removal
oScar revision
oNeck wrinkles/laxity
oBreast size
oAbdominal area
oHips/legs
oFacial contouring

Please answer the following questions:

1. **When looking at my face in the mirror, I believe I look:** [ ] Younger Than [ ] My True Age [ ] Older Than

2. **When looking in the mirror, I am:**

[ ] Not Concerned [ ] Somewhat Concerned [ ] Very Concerned

How did you hear about us?

oMy physician
oMy insurance company
oThe Yellow Pages
oA friend or family member
oDermatology and Plastic Surgery of Arizona website
oInternet
oOther

May we contact you or send you information on products, services, and special offers.

[ ] Yes [ ] No

Email address: _____ **Phone:** _____

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To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Dermatology & Plastic Surgery of Arizona

I authorize Dermatology & Plastic Surgery of Arizona to charge outstanding balances on my account to the following credit card:

Visa Mastercard American Express Other: _____

Account number _____ Expiration Date _____ CVC_____

Name on card (please print) _____Billing Zip Code_____

Signature _____ Date _____

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Release of Medical Information

Date:_____

Patient's Name:_____ Patient's Date of Birth:_____

I authorize the release of my medical information from:

Physician/Provider Name:_____

Address: _____

Phone #: ( )_____ Fax#: ( )_____

Please release:

[ ] My health information relating to the following treatment or condition(s):

_____

[ ] My health information for the date(s): _____

[ ] All my health information maintained by this office except as permitted by the Privacy Rule.

I also authorize release of any: (Please initial documents to be released)

_____ Records of treatment of drug or alcohol abuse

_____ Records of Psychiatric illness

_____ Records of HIV and AIDS.

Reason for Release: Continuity of Care, _____

_____

Please send to: _____ Christopher W. Weyer, DO _____ Jamie M. Moenster, DO _____ Geneva Daneker, FNP-C

698 E. Wetmore Rd.
Tucson, AZ 85705
Fax: (520) 777-7634 (secure fax number)

This authorization shall expire on _____ and shall not exceed six months from date of signature.

Signature of Patient or Legal Designee: _____

Reason for Legal Designee Signature: _____

Relationship of Legal Designee: ___Physician ___RN, direct request of Physician ___Staff, direct request of Physician

___ Insufficient information sent for evidence based decision making about patient's condition.

___ Patient has difficulty with accurate Medical Hx recall (Treatments, Medications, Doctor visits, Hospitalizations).

___ Gap in Patient's care, recent medical information not received. ___Other