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 Brenna Petro, 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? _____ 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? _____Have you ever smoked? _____ 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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Patient Consent to Leave Messages

Dermatology & Plastic Surgery of Arizona, in order to comply with the privacy laws, must receive a patient authorization before leaving detailed messages (possibly containing sensitive and/or protected health information) for the patient on an answering machine or voicemail. This practice is meant to protect the privacy of the patient and to protect the physicians and staff of Dermatology & Plastic Surgery of Arizona from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you consent to Dermatology & Plastic Surgery of Arizona leaving voicemails containing your/your child's medical information on the phone number(s) listed below. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.).

I, the undersigned, consent to voicemails containing my/my child's medical information at the following phone number(s):

Primary Phone: _____

(Area Code and Phone Number)

Alternate Phone (Optional): _____

(Area Code and Phone Number)

I understand that Dermatology & Plastic Surgery of Arizona cannot require me to sign this form in order to receive treatment. I understand I am entitled to a copy of this completed form.

I understand that I have the right to revoke this consent at any time by sending a written request to Dermatology & Plastic Surgery of Arizona. My decision to revoke this consent does not apply to information disclosed in a voicemail prior to the date of revocation.

By my signature below, I certify that I have read and understood the items on this form, that I have given truthful information about my/my child's identity, and that I am either the patient or the patient's legally authorized representative.

_____ **I do not consent to messages being left at home, work, cell phone, or with any other person. I wish to be contacted directly.**

Patient's Name (Please Print): _____

Date of Birth: _____

Patient's/Legal Guardian Signature: _____

Date: _____ **Witness:** _____

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Cosmetic Questionnaire

Patient Name: _____

Date:_____

What is the reason for your visit today? _____

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

[ ] Yes [ ] No

Email:_____

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