Dermatology & Plastic Surgery of Arizona | Medical History

Christopher Weyer, D.O., F.A.O.C.D. Jamie Moester, D.O., F.A.C.O.S Molly Daneker, FNP-C Candy Mungarro-Rubio, FNP Amy Weierman, PA-C

Patient Demographics			
First Name:	Middle Initial:	Last Name:	
Date of Birth:	Sex:	Reason for Visit:	
Height:	Weight:	Occupation:	Former Occupations:

Medical History

Allergies	Y	N	Cold Sores (HSV1)	Y	N	Hepatitis/Liver Disease	Y	N	Stroke	Y	N
Anxiety	Y	N	Depression	Y	N	High Blood Pressure	Y	N	STI/STD	Y	N
Arthritis	Y	N	Diabetes	Y	N	HIV/AIDS	Y	N	Thyroid Disorder	Y	N
Asthma	Y	N	Headaches/Migraines	Y	N	Hives	Y	N	Tuberculosis	Y	N
Blood Clots (DVT, PE)	Y	N	Heart Disease	Y	N	Kidney Disease	Y	N	Ulcer	Y	N
Chest Pain/Tightness	Y	N	Heart Murmur	Y	N	Seizures	Y	N	None of the Above	Y	N
Cancer If "Yes", specify here: _____	Y	N	Autoimmune Disorder If "Yes", specify here: _____	Y	N	Implanted Device/Joint If "Yes", specify here: _____	Y	N	Other Medical Issues: If "Yes", specify here: _____	Y	N

Surgical History

List all surgeries with dates, hospital, and surgeon. If none, write "none".

Type of Surgery	Estimated Date
1.	
2.	
3.	
4	
5.	
6.	
7.	
8.	

Have you ever had any issues with anesthesia in the past? If yes, please specify what type:

_____

Past Skin History

Actinic Keratosis	Y	N	Malignant Melanoma	Y	N	Tanning Bed Use	Y	N
Basal Cell Carcinoma	Y	N	Psoriasis	Y	N	Rash	Y	N
Eczema	Y	N	Scarring (Keloid or Hypertrophic)	Y	N	None	Y	N
Blistering Sunburns	Y	N	Abnormal Wound Healing	Y	N	Other Skin Issue	Y	N
Hypo/Hyperpigmentation	Y	N	Squamous Cell Carcinoma	Y	N	If yes, please specify here		

Full Name: _____ **Date of Birth:** _____

Family History Please only list mother, father, siblings, grandparents, and immediate aunts or uncles					
Diagnosis	**Relative**	**Diagnosis**	**Relative**	**Diagnosis**	**Relative**
Abnormal Bleeding		Heart Disease		Ovarian Cancer	
Blood Clots (DVT, PE)		Hemophilia		Prostate Cancer	
Autoimmune Disorder		High Blood Pressure		Skin Cancer	
Brain Tumor		Kidney Disease		Skin Disease	
Breast Cancer		Liver Disease		Stroke	
Diabetes		Lung Cancer		Von Willebrand	
Endocrine Disorder		Malignant Melanoma		None	
Other Cancers If "Yes", specify here: _____		Other Medical Issues: If "Yes", specify here: _____		Adopted/Unknown	

Allergies Please list medication, food, or seasonal allergies. Please note if you are allergic to latex or adhesives. If none, write "none".

Medications Please list all medications, both prescribed and over-the-counter, vitamins, and dietary supplements. If none, write "none".			
Name of Medication	Dosage	Frequency	Reason for Taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Preferred Pharmacy:	Pharmacy Location:		

Social History				
			Form	**Frequency**
Do you drink alcohol?	Y	N		
Do you use tobacco products?	Y	N		
Do you use any products containing nicotine?	Y	N		
Do you use any marijuana or marijuana derived substances?	Y	N		
Do you use any other recreational or illicit/illegal drugs?	Y	N		
Do you exercise?	Y	N		
Do you have any hobbies or interests?	Y	N		

New Patient Paperwork

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Patient Demographics			
First Name:	Middle Initial:	Last Name:	
Date of Birth:	Sex:	Gender Identity:	Marital Status:
Race:	Ethnicity:	Preferred Language:	
Social Security Number:	Employer:	Occupation:	

Contact Information			
Home Phone:	Cell Phone:		
Email:	Preferred Method of Contact:		
Street Address:	City:	State:	Zip Code:
Alternative Street Address:	City:	State:	Zip Code:
Billing Address (If different than above)	City:	State:	Zip Code:
Emergency Contact:	Relationship:	Phone Number:	
Primary Care Provider:	Phone Number:		

Insurance	
Primary Insurance:	Secondary Insurance:
Policy Holder:	Policy Holder:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Relationship to Policy Holder:	Relationship to Policy Holder:
Member ID:	Member ID:
Group/Policy:	Group/Policy

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.

Patient/Guardian Signature:_____ Date:_____

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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: _____ __

Dermatology & Plastic Surgery of Arizona

Cancellation Policy

If you need to cancel your appointment, please notify us of the cancellation at least 24 hours prior to your scheduled appointment. If you are unable to give us 24 hours advance notice you will be charged a "no-show" cancellation fee for your appointment of the following amount:

- Dermatology and Plastic Surgery Appointments: $50
- Cosmetic Consultation Appointments: $100*
- Excision and Mohs Surgery Appointments: $100

*Fee collected at the time of scheduling. Cancellation less than 24 hours will result in loss of $100 consultation fee. Notice of cancellation greater than 24 hours will result in 50% loss of consultation fee.

If you fail to present for your appointment three or more times without the requested advanced notification, you may be dismissed from the Practice.

Aesthetician or Laser Services Deposit and Cancellation Policy

Single Treatment Cancellations: All appointments for services must be secured with a credit card. We require a 24-hour notice for any date/time changes or cancellations of appointments. A cancellation or "no-show" fee of $100 is charged if you are within either of these time periods when canceling/rescheduling an appointment. No-show fees will be charged in full and are non-refundable. The no-show fee will be automatically charged on the credit card you authorized us to use to hold your appointment(s).

Package Deposits: Many of the procedures we offer require a significant amount of time to perform. For these procedures we require a 50% deposit of the full package price, to secure your appointment. We require a 24-hour notice to reschedule the appointment. If you choose to reschedule or cancel your first treatment of the package within less than 24-hours of your appointment time, you forfeit 50% of your deposit. Likewise, if you no-show to your first of the series appointment, you forfeit 50% of your deposit. In either situation, the 50% is non-refundable. Packages and series are required to be paid in full at the time of the first treatment. You will be required to pay your remaining balance in full at the time of the first treatment.

Packages: First series/package treatment should be started within 3 months of purchase date and completed within one year after purchase date. Packages and series are required to be paid in full at the time of the first treatment. If you are receiving a package or series of treatments, we require a 24-hour notice to reschedule the appointment. If you choose to reschedule or cancel your appointment within less than 24-hours of your appointment time, you forfeit 50% of that appointment's treatment value and will be required to pay your remaining balance prior to receiving your final treatment. The same applies to no-show appointments as well. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Returns

No Returns or Refunds on the following:
Make-up, Gift Certificates
Prepaid packages, treatments & series
Prescription products, Promotional or discounted treatments and/or products.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Signature of patient or responsible party Date

_____ _____ _____
Printed name of patient Patient date of birth Witness Initials

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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 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