PATIENT ACCOUNT NO.

PATIENT INFORMATION RECORD

SKIN CANCER SURGERY CENTER

A Division of Anne Arundel Dermatology

Please PRINT All Information

Skin Cancer Surgery Center

A division of Anne Arundel Dermatology

PATIENT INFORMATION **DATE**

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	MARITAL STATUS	AGE	DATE OF BIRTH	HAVE YOU EVER BEEN A PATIENT IN THIS OFFICE BEFORE: ☐ Yes ☐ No IF YES, WHEN?
☐ Male ☐ Female	☐ Married ☐ Single ☐ Legally Separated ☐ Divorced ☐ Unknown ☐ Widowed			

OCCUPATION	EMPLOYER
WORK ADDRESS	STUDENT STATUS Full Time Part Time Not A Student
SPOUSE'S NAME (LAST, FIRST, MI)	SPOUSE'S DATE OF BIRTH

REFERRING PHYSICIAN	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

PRIMARY INSURANCE INFORMATION

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

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER	POLICY HOLDER'S SOCIAL SECURITY NUIMBER
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 cancellations without required notice. Initial_____Date_____***

Anne Arundel DERMATOLOGY

Patient Name: _____

Date of Birth: _____

Affiliates of Anne Arundel Dermatology

Alchemy | Excel Dermatology | Rock Creek | Drs. Jaffe, O'Neill, & Lingren | Katz Dermatology | MediSpa | MD Laser Skin & Vein | Montgomery Dermatology Associates

DAK Dermatology Associates of Knoxville | Maryland Dermatology Associates | East Tennessee Dermatology Group | knoxville dermatology group | Virginia Dermatology | Skin Cancer Surgery Center | Tideway Dermatology

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 (AAD") 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 AAD 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 AAD. 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 AAD 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 AAD 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 AAD act on my behalf to obtain my benefits when AAD asks to do so. I also agree that AAD 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.

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 AAD 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 AAD 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 AAD practice locations may be made available to subsequent AAD-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 AAD 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 AAD. 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, 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, and general health via text.

__I hereby revoke my request to receive any future appointment reminders, feedback, 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 AAD'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: _____

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

Anne Arundel DERMATOLOGY
and Affiliate Practices

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)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat) Bone Marrow Transplantation
BPH (Enlarged Prostate)
Cancer: Type(s) _____
_____
_____
COPD (Chronic Obstructive Pulmonary Disease)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal (Kidney) Disease GERD (Acid Reflux)
Hearing Loss
Hepatitis/Liver Disease
Hypertension(High Blood Pressure) HIV/ AIDS
Hypercholesterolemia (High Cholesterol)
Hyperthyroid (Overactive Thyroid)
Hypothyroid (Underactive Thyroid)
Radiation Treatment
Seizures
Stroke
None
OTHER: _____
_____

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

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Lumpectomy (Both Breasts)
Breast: Lumpectomy (Left Breast)
Breast: Lumpectomy (Right Breast)
Breast: Mastectomy (Both Breasts)
Breast: Mastectomy (Left Breast)
Breast: Mastectomy (Right Breast)
Breast: Breast Biopsy
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gall Bladder(Cholecystectomy): Removed
Heart: Coronary Artery Bypass Surgery
Heart: PTCA(Coronary Angioplasty)
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement: Knee (Both)
Joint Replacement: Knee (Left)
Joint Replacement: Knee (Right)
Joint Replacement: Hip (Both)
Joint Replacement: Hip(Left)
Joint Replacement: Hip(Right)
Kidney: Kidney Biopsy
Kidney: Nephrectomy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Liver: Shunt
Liver: Liver Transplant
Liver: Hepatectomy
Ovaries(Oophorectomy): Endometriosis
Ovaries(Oophorectomy): Ovarian Cyst
Ovaries(Oophorectomy): Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas: Pancreatecomy
Prostate(Prostatectomy): Prostate Cancer
Prostate(Prostatectomy): Prostate Biopsy
Prostate:TURP(Transurethral Resection of the Prostate)
Rectum: APR(Abdominoperineal Resection)
Rectum: Lower Anterior Resection
Skin: Biopsy
Skin: Basal Cell Carcinoma
Skin: Squamous Cell Carcinoma
Skin: Melanoma
Spleen (Splenectomy)
Testicles(Orchiectomy)
Uterus(Hysterectomy): Fibroids
Uterus(Hysterectomy): Uterine Cancer
Uterus(Hysterectomy): Cervical Cancer

OTHER: _____

Please fill in reverse side of sheet also

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis (pre-cancerous lesions)
Asthma
Basal Cell Skin Cancer
Blistering Sun Burns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/ Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Cancer
Other: _____

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	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Arthritis	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Asthma	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Diabetes	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Eczema	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Hay Fever/Allergies	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Lupus	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Psoriasis	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None
Non-Melanoma Skin Cancers	□ Mother	□ Father	□ Sister	□ Brother	□ Daughter	□ Son	□ Other	□ None

Review of Systems: Do you have or are you currently experiencing any of the following? (Please circle yes or no)

Changing mole	Yes	No	Muscle weakness	Yes	No
Rash	Yes	No	Neck Stiffness	Yes	No
Fever or chills	Yes	No	Headaches	Yes	No
Depression	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Cough	Yes	No
Problems with healing	Yes	No	Shortness of breath	Yes	No
Problems with bleeding	Yes	No	Wheezing	Yes	No
Problems with scarring (hypertrophic or keloid) Immunosuppression	Yes	No	Pacemaker	Yes	No
	Yes	No	Defibrillator	Yes	No
Hay fever	Yes	No	Blood thinners	Yes	No
Chest pain	Yes	No	GI upset with antibiotics	Yes	No
Night sweats	Yes	No	Allergy to adhesive	Yes	No
Unintentional weight loss	Yes	No	Allergy to lidocaine	Yes	No
Thyroid problems	Yes	No	Allergy to topical antibiotic ointments	Yes	No
Sore throat	Yes	No	Artificial heart valve	Yes	No
Blurry vision	Yes	No	Artificial joint within the past 2 years	Yes	No
Abdominal pain	Yes	No	MRSA	Yes	No
Bloody stool	Yes	No	Premedication prior to procedures Rapid heartbeat with epinephrine	Yes	No
Bloody urine	Yes	No		Yes	No
Joint aches	Yes	No	Pregnancy or planning a pregnancy	Yes	No

Immunizations: Have you had the following immunizations?

Vaccine:	**Date of Vaccination (can be approximate if unsure):**
Influenza (Flu)	_____
Pneumonia	_____
Varicella (Shingles)	_____

Anne Arundel DERMATOLOGY
and Affiliate Practices

Today's Date: _____

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:** _____

Anne Arundel DERMATOLOGY
and Affiliate Practices

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? **Yes**

   If NO, select reason why: Refused / Allergy

For Patients 65 years and older

3. Have you ever had a Pneumonia Vaccine (Prevnar 13 and/or Pneumovax 23)?
   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: _____ **Referring Dermatologist:** _____