

Date: _____

Patient Name: _____ SS#: _____ Date of Birth: _____ M F

Address: _____

City: _____ State: _____ Zip: _____ Phone No: _____

Email:

Referred by: Please enter physician's full name: _____

Primary Care Physician: Please enter physician's full name: _____

Current Marital Status: Married Single Divorced Widow/Widower

Employer: _____ Occupation: _____

Employer Address: _____

In case of Emergency contact: _____ Relation: _____

Address: _____ Phone No: _____

Do you have medical insurance: No Yes—please list the following:

Primary Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured: _____ M F

Marital Status: _____

Insured SS#: _____

Relationship to Insured: _____

Insured's Date of Birth: _____

Policy No: _____

Group No: _____

Insured's Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured: _____ M F

Marital Status: _____

Insured SS#: _____

Relationship to Insured: _____

Insured's Date of Birth: _____

Policy No: _____

Group No: _____

Insured's Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Please note our office policy states that payment for services that are not to be billed to insurance are due at the time of visit. If we are billing your insurance carrier and you have a co-pay, please pay at the time of service. Thank you.

PLEASE READ THE FOLLOWING, SIGN, AND DATE. THANK YOU.

I hereby authorize Rajiv Kwatra, M.D. to furnish the above insurance company(s) all medical information necessary to process any appropriate claim(s). I also authorize payment of medical benefits to Rajiv Kwatra, M.D. I accept full responsibility for ALL my incurred charges including charges which my insurance company may or may not cover. I am responsible for all charges incurred for the treatment/services I receive, whether I have or may not have insurance.

Patient or Guardian's Signature _____ Date _____

Medical History and Consent

Name: _____ Age: _____ Date of Birth _____ M F

Occupation _____

Current Marital Status: Married Single Divorced Widow/Widower

Primary Care Physician _____ None

Dermatologist _____ None

Referring Physician _____ None

MEDICATIONS:

What medications are you currently taking including over the counter medicines and vitamins?

None Yes — Please list: _____

Are you currently taking Aspirin? No Yes if no and you stopped recently, how long since you had your last dose: _____ days

Do you take high dose Vitamin E (200-400 units/day) No Yes if no and you stopped recently, how long since your last dose _____ days

ARE YOU ALLERGIC TO ANY MEDICATIONS?

No Yes — Please list: _____

CURRENT SKIN PROBLEM:

Location of skin problem(s) today: _____

How long has this problem been present? _____

Has the area been biopsied: No Yes —by whom and when: _____

Check all that apply to today's problem: Change in: Size Color Texture Shape

Other _____

Symptoms: None Bleeding Pain Tingling Ulceration Infection Itching

Other _____

SOCIAL HISTORY:

Do you smoke? No Yes — I have smoked _____ packs per day for _____ years.

If you are a former smoker, no matter how long ago, please fill in the blanks:

I have smoked _____ packs a day for _____ years.

Do you drink alcohol? None Less than one drink daily 1-2 drinks daily 3 or more drinks daily

Do you wear sunscreen? No Yes If yes — SPF _____

HISTORY:

Have you had any plastic surgery in the past: No Yes — please list all procedures and when: _____

Do you have Diabetes: No Yes — how long: _____

Are you taking medications that suppress your immune system: No Not sure Yes — name of medication: _____

Medical History and Consent

Name: _____

HISTORY CONTINUED

Please list any CURRENT major illnesses: _____

Do you have a history of previous skin cancers? No Yes — please list _____

History of exposures to area: X-ray or Radiation Ultraviolet light

Have you used tanning beds in the past: No Yes — how often and for how many years: _____

Do you have a family history of skin cancer: None

Basal Cell Cancer, which relative _____

Squamous Cell Carcinoma, which relative _____

Melanoma, which relative _____

Other _____

HEALTH

SKIN: Normal Slow Healing Hypertrophic Scarring Keloids

Other _____

BLEEDING PROBLEMS: None Low Platelets Anemia

Other _____

CARDIOVASCULAR: Normal Pacemaker Artificial Heart Valve Angina (chest pain)

High Blood Pressure Heart Attack — When: _____

Other _____

MUSKULOSKELETAL: Normal Arthritis Artificial Joints — please list: _____

Other _____

EYES/EARS/NOSE/THROAT: Normal Hearing Aid Impaired Vision — please list problem and which eye: _____

Other: _____

GASTROINTESTINAL: Normal Ulcers Colitis Irritable Bowel

Other _____

Endocrine: Normal Diabetes Thyroid Problems

Other _____

NEUROLOGICAL: Normal Stroke Seizures

Other _____

RESPIRATORY: Normal Asthma Emphysema

Other _____

PSYCHIATRIC: Normal Anxiety Depression

Other _____

INFECTIONS: None Hepatitis B Hepatitis C HIV/AIDS Tuberculosis

Other _____

The answers I have provided are true to the best of my knowledge. I understand that in the course of my visit today tests may be required for evaluation and diagnosis. A skin biopsy is often required and can leave a scar where it is taken from. I hereby give my consent to be evaluated and have tests performed such as a skin biopsy as necessary:

Signature/patient or power of attorney (guardian)

Date

Name _____ Date _____

Pharmacy information:

Pharmacy Name _____
Crossroads or Address _____
Phone number _____

Medications:

Do you have any changes in your medications?

Vaccination Status:

Have you received an influenza immunization? NO YES If yes, When _____

Have you received an pneumonia immunization? NO YES If yes, When _____

Social History:

How often do you drink alcohol? NEVER OCCASIONALLY WEEKLY DAILY

Do you smoke? NO FORMER SMOKER YES if yes, I have smoked _____ packs per day for _____ years.

Falls:

Have you fallen in the past 12 months? YES NO If yes, how many times _____

Do you use a WHEELCHAIR WALKER CANE OTHER

Advanced Care:

Do you have a health care proxy in the event you are unable to make your own medical decisions? NO YES If yes, Name _____ phone # _____

Do you have a living will? NO YES

Which statement best reflects your wishes on advanced care recommendations?

___ 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 is necessary to save my life.

___ FULL CARDIOPULMONARY RESUSCITATION: I want full cardiopulmonary resuscitation efforts to be made.

Dermatology Associates

9250 N 3rd St Suite 3025 Phoenix, AZ 85020

Phone: 602-944-4628 Fax: 602-944-2805

Notice of Privacy Practice Acknowledgment

Health Insurance Portability and Accountability Act (HIPAA)

I acknowledge that I have received a copy of the Notice of Privacy Practice Acknowledgment (HIPAA) for Dermatology Associates, in accordance with the Federal Government Health Insurance Portability and Accountability Act.

Print Patient Name: _____ Date: _____

Patient Signature / Patient Legal Guardian:

Relationship: _____

Acknowledgment of Receipt of Privacy

Notice and Patient Rights and Responsibilities

I acknowledge that I have received a copy of the office's Notice of Privacy Practices and Patient Rights and Responsibilities for Dermatology Associates.

Print Patient or Legally Authorized Individual:

Patient or Legally Authorized Individual Signature:

Print Name if Signed on behalf of the Patient:

Relationship: _____ Date: _____

Ask front desk to print copy of form if needed

NO SHOW FEE CONSENT

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Dermatology Associates sends text messages reminders 2 business days in advance or 1 phone call reminder the day before.

****OFFICE IS CLOSED ON FRIDAY****

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a **\$25.00** "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

Patient Name: _____

Signature: _____

Date: _____

Dermatology Associates

9250 N 3rd St Suite 3025 Phoenix, AZ 85020

Phone: 602-944-4628 Fax: 602-944-2805

RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____

I hereby DO NOT authorize the release of medical information to family member(s), Guardian, and others.

I hereby authorize the release of medical information to family member(s), Guardian, and others.

Name: _____

Relationship: _____ Number: _____

I understand that I have the right to revoke this authorization, in writing at any time. I understand that such revocation is not effective to the extent that the medical office has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclose by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

Signature: _____

Date: _____