Huntington DERMATOLOGY
a DOCS affiliate

PRACTICE UPDATES

1. Update all of your history on the form provided to you.
    a. Check name, address, phone number, etc.
    b. List any new medical problems or surgeries
    c. Please, correct any information that is incorrect.

2. Be prepared to have your prescriptions E-MAILED directly to your pharmacy, which is now REQUIRED by the government. We can provide you with a paper copy upon request, but your prescription cannot be called in, faxed, or hand-delivered.

3. We are currently working toward an online Patient Portal. As a preliminary step, please provide your e-mail address on the form or directly to a staff member. **This must be a private e-mail address to which only you have access. Anyone with access to this account will receive e-mails pertaining to your health record.**

4. This office is required to participate in a process called ***"Meaningful Use***". We must demonstrate to the government that our electronic medical records are being used in a way that they deem appropriate. For this reason, **we must require** some additional details about every patient's medical history. The following information **must be completed** today!

MEANINGFUL USE – (REQUIRED INFORMATION)

1. If over the age of 13, do you use tobacco products? If so, how often and how much?_____

2. Are you interested in information on smoking cessation?_____

3. If over the age of 18, do you drink alcoholic beverages? If so, how often and how much?_____

4. Have you received an influenza vaccination in the past 12 months? If so, when?_____

5. Have you received a pneumonia vaccine in the past 12 months? If so, when?_____

6. If over the age of 18, do you have an **Advanced Care Plan, also known as a Living Will** or a **Surrogate Decision Maker** in place? **This is defined as a person designated to make decisions on your behalf if you are unable?** If yes, please provide the following:

    Name_____ Phone Number_____
    Address_____

7. If over the age of 12, have you experienced any anxiety or depression?_____
    If yes, do you have little to no interest in activities?_____
    If yes, do you feel down, depressed, and/or hopeless?_____
    Please list any issues you have concerns about depression._____

NAME_____DATE_____

Huntington Dermatology, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act if 1996 requires healthcare providers to make available a copy of the Notice of Privacy Act for the office, and make a good faith effort to obtain an acknowledgement of receipt of that Notice of Privacy Act. You may refuse to sign this form.

By signing this form you confirm that a copy of the Notice of Privacy has been made available to you.

Print Name: _____

Signature: _____ Date: _____

Please **list Family Members or people that you can trust** that our office can release your current health information to if you are not available.

1. _____ Phone _____
2. _____Phone_____

If patient refuses signature please state why and sign form: _____
_____

Financial Policy

We will bill all primary insurance companies and any secondary insurance for our patients. Please provide us with complete and accurate insurance information, as well as current address, telephone number, and employer information for you. All Co-pays, deductibles, and coinsurances will be collected prior to seeing the physician. We accept cash, check, Visa, Mastercard, and Discover. Your insurance coverage is a contract between you and your insurance company. You are responsible for payment of your account. Questions regarding insurance payment should be directed to your carrier. The "usual and customary charge" is the amount paid by your insurance company and is determined by their budget. This does not reflect the actual charge for a procedure. Itemized statements will be issued monthly and will reflect the status of your account.

I request that payment of authorized Medicare and all other benefits be made on my behalf to Huntington Dermatology, Inc. for any services provided by Huntington Dermatology, Inc. I authorize the release of healthcare financing administration and its agents any medical information necessary to determine these payments for related services.

Signature: _____ Date: _____

Huntington Dermatology, Inc.
Medical History Form

Patient Name_____ **Date of Birth**_____

Reason for today's visit_____

List of Medications you are currently taking_____

_____

Do you have any allergies to any medications { } Yes { } No; If yes please list_____

_____

List any surgical procedures you have had and the year they were performed_____

_____

List any recent hospitalizations for illness in the past 6 months_____

_____

*****Please mark, yes or no, and explain where needed beside the question*****

Social History		**If Yes, Please Explain**
Are you currently working outside the home? If yes, please indicate occupation.	○ Yes ○ No	
Have you traveled outside the US in the past three months? If yes, where?	○ Yes ○ No	
Do you drink alcoholic beverages? If yes, how often.	○ Yes ○ No	
Do you use tobacco products? If yes, how often and how much?	○ Yes ○ No	
Are you interested in information on smoking cessation?	○ Yes ○ No	
Do you currently use recreational drugs?	○ Yes ○ No	
Do you exercise on a regular basis?	○ Yes ○ No	
Have you, or are you currently using a tanning salon?	○ Yes ○ No	
Have you had at least one blistering sunburn in your life?	○ Yes ○ No	
Do you wear sunscreen regularly?	○ Yes ○ No	
Family History (Please answer even if Family Member is Deceased)		
Does/Did your mother have any major medical problems? If yes, list.	○ Yes ○ No	
Does/Did your father have any major medical problems? If yes, list.	○ Yes ○ No	
Is there any family history of melanoma? If yes please list which relatives.	○ Yes ○ No	
Do/Did you siblings have any major medical problems? If yes, list.	○ Yes ○ No	
Past Medical History (Have you ever had any of the following?)		**If Yes, Body Location**
Melanoma	○ Yes ○ No	
Basal Cell Carcinoma	○ Yes ○ No	
Squamous Cell Carcinoma	○ Yes ○ No	
Dysplastic Nevus	○ Yes ○ No	

Review of Systems (Have you ever had any of the following?)				If Yes, Please Explain
INFECTIOUS	Tuberculosis	○ Yes	○ No	
	HIV/AIDS	○ Yes	○ No	
	Hepatitis B or C	○ Yes	○ No	
	Enlarged Lymph Nodes	○ Yes	○ No	
	Herpes	○ Yes	○ No	
	Cold Sores	○ Yes	○ No	
	Warts	○ Yes	○ No	
GASTROINTESTINAL	Hepatitis	○ Yes	○ No	
	Stomach Ulcers	○ Yes	○ No	
	Liver Disease	○ Yes	○ No	
RENAL	Kidney Disease	○ Yes	○ No	
	Dialysis	○ Yes	○ No	
PULMONARY	Asthma	○ Yes	○ No	
	Shortness of Breath	○ Yes	○ No	
	Bronchitis	○ Yes	○ No	
	Sarcoidosis	○ Yes	○ No	
ENDOCRINE	Diabetes	○ Yes	○ No	
	Thyroid Disease	○ Yes	○ No	
HEMATOLOGIC	Anemia	○ Yes	○ No	
	Low White Blood Cells	○ Yes	○ No	
	Low Platelets	○ Yes	○ No	
	Bruise or Bleed Easily	○ Yes	○ No	
	Blood Clots	○ Yes	○ No	
	Lymphoma/Leukemia	○ Yes	○ No	
	Sickle Cell Anemia	○ Yes	○ No	
	Cancer (other than skin)	○ Yes	○ No	
CARDIOVASCULAR	Heart Murmur	○ Yes	○ No	
	Heart Valve	○ Yes	○ No	
	Pacemaker	○ Yes	○ No	
	High Blood Pressure	○ Yes	○ No	
	Varicose Veins	○ Yes	○ No	
	Coronary Artery Disease	○ Yes	○ No	
	Low Blood Pressure	○ Yes	○ No	
MUSCULOSKELATAL/RHEUMATOLOGIC				
	Artificial Joint	○ Yes	○ No	
	Arthritis	○ Yes	○ No	
	Joint Pain	○ Yes	○ No	
	Muscle Pain	○ Yes	○ No	
	Gout	○ Yes	○ No	
	Lupus	○ Yes	○ No	
PSYCHIATRIC	Depression	○ Yes	○ No	
	Anxiety	○ Yes	○ No	
	Phobia	○ Yes	○ No	
	Bulimia/Anorexia	○ Yes	○ No	
	Chemical Dependency	○ Yes	○ No	
GYNECOLOGY (female patients only)				
	Irregular Menstrual Cycles	○ Yes	○ No	
	Menopause	○ Yes	○ No	
	Pregnancy	○ Yes	○ No	
	Excessive Bleeding	○ Yes	○ No	

	Endometriosis	○ Yes	○ No

Patient Name: _____ **Date:** _____

EENT	Glaucoma	○ Yes	○ No
	Sinus Infection	○ Yes	○ No
	Cataracts	○ Yes	○ No
NEUROLOGIC	Seizures	○ Yes	○ No
	Fainting	○ Yes	○ No
	Headaches	○ Yes	○ No
	Stroke	○ Yes	○ No
DERMATOLOGIC	Hives	○ Yes	○ No
	Skin Ulcers	○ Yes	○ No
	Itching	○ Yes	○ No
	Skin Cancer	○ Yes	○ No
	Acne	○ Yes	○ No
	Eczema	○ Yes	○ No
	Psoriasis	○ Yes	○ No
	Hair Loss	○ Yes	○ No
	Nail Problems	○ Yes	○ No
	Sun Sensitivity	○ Yes	○ No
	Reaction to Jewelry	○ Yes	○ No
	Rosacea	○ Yes	○ No
	Trouble healing	○ Yes	○ No
	Tend to form keloids	○ Yes	○ No
	Reaction to band-aids	○ Yes	○ No
	Reaction to antibiotic ointment	○ Yes	○ No
	Latex allergy	○ Yes	○ No

Patient Name: _____
(please print)

Patient Signature: _____ **Date:** _____

HUNTINGTON DERMATOLOGY, INC.

PATIENT REGISTRATION **CONFIDENTIAL**

DATE_____

Family Physician/Primary Care Physician **TEL#** _____ _____ _____

Patient Name_____ **Date of Birth** _____ **Age** _____
Proper First Name Middle Last Name

Patient Address _____
Street City State Zip Code

Phone Numbers Home ( )_____ **Cell ( )**_____ **Work ( )**_____

If patient is under 18- Parent/Guardian Name_____**Tel#**_____

E-MAIL ADDRESS_____ **SS#**_____

Best Time and Place/Number to reach you_____

Gender [ ] **M** [ ] **F** **Marital Status** [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated [ ] Minor

Preferred Language_____ **Race**_____ **Ethnicity** [ ] hispanic [ ] non hispanic

Patient Employer _____ **Occupation** _____

Employed [ ] Unemployed [ ] Retired [ ] College Student [ ]

Your Preferred Pharmacy Name and Location_____**Tel#**_____

Lab required by your Insurance Co. (IF ANY): [ ] St. Marys Hospital, [ ]Cabell Hunt. Hospital, [ ] Lab Corp, [ ] other

EMERGENCY CONTACT: Important Information DO NOT LEAVE BLANK . SOMEONE YOU TRUST TO GET A MESSAGE TO YOU. Address and Phone Number Must Be Different From Patient or Responsible Party.

Name_____ **Relationship** _____

Address _____

Home Phone Number _____ **Cell Phone Number** _____

INSURANCE INFORMATION "MUST" BE COMPLETE FOR PROPER SUBMISSION OF YOUR CLAIM

Primary Insurance Carrier _____ **Employer** _____

ID Number _____ **Group Number** _____

Policyholder Name _____ **Date of Birth** _____

Relationship to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Step Parent [ ] Other _____

Secondary Insurance Carrier _____ **Employer** _____

ID Number _____ **Group Number** _____

Policyholder Name _____ **Date of Birth** _____

Relationship to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Step Parent [ ] Other _____

REFERRAL INFORMATION

Referring Doctor _____ **Tel#**_____ _____

PLEASE BE PREPARED TO GIVE THE RECEPTIONIST A COPY OF CURRENT INSURANCE CARDS AND A PICTURE ID