Lakeside Dermatology

Welcome to our practice. We appreciate the opportunity to care for you.

Patient Name_____ DOB_____ *Today's Date____/____/____*

Please check all of the following boxes that apply:

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ BPH (enlarged prostate)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Gastric Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:_____
- ☐ *No Past Medical Problems*

Past Surgeries

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Breast Reduction
- ☐ Breast: Breast Implants
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Dz
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: PTCA (angioplasty)

Past Surgeries Continued

- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Heart Transplant
- ☐ Joint Replacement: Knee (Right)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Nephrectomy (Kidney Removal)
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Skin: Skin Biopsy
- ☐ Skin: Basal Cell Carcinoma Surgery
- ☐ Skin: Squamous Cell Carcinoma Surgery
- ☐ Skin: Melanoma Surgery
- ☐ Spleen (Splenectomy): Spleen Removal
- ☐ Testicles (Orchidectomy): Testicle Removal
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Other:_____
- ☐ *No Past Surgical Procedures*

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratoses (precancers)
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ *No Past Skin Problems*

Skin History

Do you wear sunscreen?

- ☐ Yes. What SPF do you apply?_____
- ☐ No

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Family History

Is there a family history of melanoma?

- ☐ Yes. Which relative(s)?_____
- ☐ No

Medications: (Please list all medications, including over the counter, supplements, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

☐ *No Current Medications*

Allergies: (Please list all allergies)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

☐ *No Drug Allergies*

Sexual History

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with two or more partners
- ☐ Same gender partner

Drinking Alcohol History

- ☐ No alcohol
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Smoking History

- ☐ Currently smokes daily
- ☐ Currently smokes but not daily
- ☐ Former smoker
- ☐ Has never smoked

Review of Systems *Have you recently experienced any of the following:*

- ☐ Changing , bleeding or itching mole/lesion
- ☐ Rash
- ☐ Itching
- ☐ Burning Skin
- ☐ Fever/Chills
- ☐ Unintentional Weight Loss
- ☐ Night Sweats
- ☐ Muscle Weakness
- ☐ Joint Aches
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Blurry Vision
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Abdominal Pain/Nausea/Vomiting
- ☐ Bloody Stool
- ☐ Depression
- ☐ Hay Fever
- ☐ Problems Healing
- ☐ Burning with urination
- ☐ Heat or cold intolerance
- ☐ Frequent nose bleeds
- ☐ *Does not apply*

Alerts *Important info to know about you:*

- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Artificial Joint Placed in Last 2 Years
- ☐ Artificial Heart Valve
- ☐ Antibiotic Prophylaxis
- ☐ History of Scarring (Keloid)
- ☐ History of Passing Out (Vasovagal)
- ☐ Organ Transplant Recipient
- ☐ Immunosuppressed (Low Immunity)
- ☐ Allergy to Adhesive
- ☐ Pregnant or Planning a Pregnancy
- ☐ Breast Feeding
- ☐ Stomach Upset with Antibiotics
- ☐ Yeast Infection with Antibiotics
- ☐ Allergy to Topical Antibiotics
- ☐ Anti-coagulated (on blood thinners)
- ☐ Allergic to Lidocaine
- ☐ Rapid Heart Beat with Epinephrine
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ History of MRSA
- ☐ *Does not apply*

Female Patients Only

Are you pregnant?

- ☐ Yes Due Date_____
- ☐ No

Are you breast feeding

- ☐ Yes
- ☐ No

Are you trying to get pregnant?

- ☐ Yes
- ☐ No

Primary Care Physician

_____

Phone_____

Address_____

Prescription Coverage

- ☐ Yes
- ☐ No

Preferred Pharmacy _____

Phone_____

Zip code_____

Preferred Language:

- ☐ English
- ☐ Other:_____

Race:

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other Race:_____

Ethnic Group:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

65 & Older Only

Did you receive your Pneumonia Vaccine?

- ☐ Yes
- ☐ No

Reviewed by: _____ Date: _____

The notice of privacy practice for the office of Lakeside Dermatology, LLC is available at the front desk and on our website at **www.dermatlakeside.com**. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1 of this document provides your acknowledgement that you have read our Notice of Privacy Practices.

Section 2 requests your response to notification format and designation of a family member or other designee that we may contact and discuss your medical care in the event of an emergency or for the purpose of the individual items as checked below.

Section 3 provides the opportunity to opt in or opt out of receiving marketing communication from our office.

Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office Lakeside Dermatology, LLC

_____ _____

Patient Name *Date*

Section 2 – Notification and Emergency Designee

I give permission to Lakeside Dermatology, LLC and staff to perform the following duties in an effort to maintain continuity of care.

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.

☐ **YES** ☐ **NO**

Leave a message of normal test result on my home answering machine or with a specified family member.

☐ **YES** ☐ **NO**

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

_____

Designated Person *Contact Number*

Section 3 – Marketing communication.

Lakeside Dermatology would like to share new product, discounts or service information directly to you, our patient. The information may be communicated by phone call, letter, or email. You have the right to **Opt In** or **Opt Out** of any marketing communications by checking your preference on the boxes below. (***You are able change to your decision at any time by notifying our office.)***

☐ **I wish to opt IN** and receive marketing and other communications via email, phone call or letter:

☐ **I wish to opt OUT; I do not** wish to receive marketing information.

I understand the information provided to me in the privacy notice and I have indicated my response to questions in each section.

_____ _____

Patient Signature and Phone number *Date*

Patient Responsibility Policy

Patient Name:_____ DOB:_____

Patient Email Address: _____

Referred By: □Physician:_____ □Family/Friend:_____

1. ***If you have a HMO insurance, you are responsible for obtaining your referral from your doctor.*** Referrals are only valid for 90 days from issue date and valid for as many visits as your primary doctor has approved, unless your insurance policy states otherwise. If your referral from your PCP is not valid at the time of your visit, you may be responsible for your balance in full.

2. You are responsible for knowing the policies of your insurance, such as: co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc.

3. Co-pays and Self-pay procedures are due at the time of service, no exceptions. **We accept payment in the form of cash, check, or credit card.** If we do accept a check for payment, and if the check does not clear the bank, a **$37.00** service fee will be automatically added to your account. An 18% Service Fee will be added to all account balances forwarded to our collection agency.

4. If you need to cancel and/or reschedule an appointment, please notify the office 48 hours in advance.

5. For the consideration of our patients who want to be seen, if you repeatedly cancel less than 48 hours in advance or no show your appointment, we have the right to discharge you as a patient.

Please call the office if you are going to be late to your appointment. It will be up to the discretion of the physician if you will be seen if you arrive more than 20 minutes late.

I authorize the release of medical information to my primary care and/or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

To establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. **Please note that any procedure performed in the office may be billed separately and in addition to the office visit fee.** Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the patient responsibility policy of Lakeside Dermatology LLC.

Signature: _____ Date: _____