Dermatology Medical History

Patient: _____ Date of Birth::___/___/___ Today's Date: ____/___/___

Reason for today's visit: _____Preferred pharmacy:_____

Past Medical History**:** Do you have now, or have you ever had diseases or conditions of: (Check YES or NO)

Lungs:	**YES**	**NO**
COPD	❑	❑
Emphysema	❑	❑
Asthma	❑	❑

Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**YES**	**NO**
Diabetes	❑	❑
Thyroid Problems	❑	❑
Kidney Problems	❑	❑
Dialysis	❑	❑
Bladder Problems	❑	❑
Hepatitis	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Arthritis/Joint Deformity	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑
Stroke	❑	❑
Exposure to HIV/AIDS	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last six (6) months: _____ List any joints you have had replaced in the last three (3) years: _____

Skin: Have you ever had skin cancer? ❑ YES ❑ NO

Has anyone in your family had skin cancer? ❑ YES ❑ NO

Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____ Do you develop skin rashes in reaction to: ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Neosporin ❑ Other _____

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, & herbals):

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

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

Social History:

Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day

Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____

Current Smoker? ❑ YES ❑ NO If YES, how much:_____ If NO, have you ever smoked? ❑ YES❑ NO

What is your occupation? _____ Hobbies? _____

Review of Systems:

Skin:	**YES**	**NO**
Problems with healing?	❑	❑
Do you develop keloids (scars) after surgery ?	❑	❑
Do you bleed easily?	❑	❑

Lungs/Cardiovascular:	**YES**	**NO**
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑
Chest Pain	❑	❑

Are you pregnant?	**YES**	**NO**
Due Date: __/__/__	❑	❑

Other Systemic:		
Frequency/burning with urination	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthralgia (joint pain)	❑	❑
Limited joint motion	❑	❑

Patient Registration Form

Name: _____ Date of Birth: _____ Preferred Name: _____

Permanent Billing Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Marital Status: (M / S / D / W) Gender: (M / F) Preferred Language: _____

Race: _____ Hispanic or Latino Decent? (Y / N) Employer: _____

Email: _____ Can we leave a detailed message on your voicemail? (Y / N)

Preferred Phone #: (_____) _____ (Home/Mobile/Work)

Secondary Phone #: (_____) _____ (Home/Mobile/Work)

Emergency Contact: _____ Phone #: _____

Primary Insurance: _____ Member ID: _____

Policy Holder Name: _____ & Date of Birth: _____

Policy Holder Address: _____ State: _____ Zip: _____

Relationship to Patient:_____ Group #:_____

Secondary Insurance: _____ Member ID: _____

Policy Holder Name: _____ & Date of Birth: _____

Policy Holder Address: _____ State: _____ Zip: _____

Relationship to Patient: _____ Group #:_____

Permission to Discuss Your Medical Information: (*Ex: Spouse, Caretaker, Other Physician…etc)*

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____

Guarantor for a Minor: **(*Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.) If the minor patient under your care will not have you present at each office visit after today please ask the receptionist for a minor care consent form.***

Name: _____ Date of Birth: _____Relationship to Patient: _____

Address: _____

Street Address, Number, City, State & Zip

Consent for Treatment Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

My signature below indicates that I have received and/or reviewed a copy of Alpine Dermatology Clinics Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). My signature also indicates that I understand Alpine Dermatology Clinic reserves the right to change the terms of its Notice of Privacy Practices. I understand I can obtain Alpine Dermatology Clinic's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

MEDICARE ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
MEDIGAP (Medicare Supplement) If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Alpine Dermatology Clinic, PC. I authorize Alpine Dermatology Clinic, PC to provide to my insurance company, any information necessary to process claims for services rendered to me.

Signature: _____ Date: _____

How did you hear about us?

(Please circle) Insurance Plan Other Physician Internet TV Family/Friend

Social Media Radio Billboard Printed Other: _____

FINANCIAL POLICY

PAYMENT DUE AT TIME OF SERVICE: As a courtesy, we will file your claim to your insurance company for you. **The amount for which you are responsible – deductibles, copayments, coinsurance percentages or non-covered services - is required at the time of service**.

If we are not contracted with your insurance plan, the total cost of your visit will be patient responsibility. We strongly recommend that you contact your insurance company to determine if we are contracted with your policy. For your convenience in paying, our office accepts Discover, MasterCard, American Express and Visa in addition to cash and checks.

FINANCIAL PROMISSORY FORM: If you are unable to pay at the time of service, you will be required to sign a Financial Promissory Form. You will have 5 business days to submit payment to Alpine Dermatology before an additional $5 administrative fee will be added to the original copayment, deductible and coinsurance due**.** Payment plans are also available and can be set up with a receptionist.

FLEX/HEALTH SAVINGS PLANS: Payment is due at the time of service. Therefore, we do not wait to receive payment after the flex or health savings plan reimburses you. We will provide an itemized receipt for you to submit to your flex or health savings plan for reimbursement.

LATE FEES: A fee of $5 will be added to your account each month the balance is overdue. An overdue balance is considered to be 30 days after the balance becomes patient responsibility.

COLLECTION AGENCY FEES: If payment is not received within 90 days of patient responsibility, your account will be reviewed for collections. If your account is turned to a collection agency, all reasonable costs and attorney's fees will be added to the account balance.

NO SHOW/CANCELLATION FEES: Missed appointments will result in limited available time options. After two missed, cancelled or rescheduled appointments (or one surgery) without 24 hour notice, a $25 fee will be required to schedule further appointments. Alpine Dermatology may also reserve the right to refuse to further schedule and treat the patient.

RETURNED CHECKS: If a check written by you or on your behalf is returned, you will be charged a $25 returned check fee. You will be required to pay cash or use a credit/debit card for all future appointments.

COST ESTIMATES: If at any time you are concerned about the cost of a procedure proposed by the doctor, we recommend that you request to discuss the costs and possible payment options with the office manager ***prior*** to treatment.

If you have any questions concerning our Financial Policy and fees or if you foresee difficulty making payment, please speak to a receptionist or request to speak to the office manager ***before*** signing below.

Signature: _____ Date: _____

Acknowledgement of Services Provided by a Physician Assistant (PA)

Alpine Dermatology Clinic, PC employs physician assistants who work under the supervision of Dr. Marshall in providing services to patients. A physician assistant is a medical professional who is nationally certified and state-licensed to practice medicine. All PAs are graduates of an accredited PA educational program. It is important that patients seeking care from medical professionals are educated about the differences between a PA and a physician and the role of physician assistants in any given practice.

How are PAs educated and trained?

A PA receives both classroom and clinical instruction for an average period of 26 months. This training mirrors medical school curriculum, but because of the shorted time frame is not as in depth and is not considered "medical school." Clinical rotations are completed with emphasis in primary care. Graduates of accredited PA programs are eligible to take the Physician Assistant National Certifying Exam (PANCE). PA graduates who pass the PANCE and maintain certification may use the title Physician Assistant-Certified or PA-C.

Once formal training and certification processes are complete a PA can obtain employment in any medical specialty. Their training continues in that specialty under the direction of their supervising physician. PAs are not medical specialists like physicians who complete additional residency training in specific specialties and then take board certification exams in their respective specialty. A PA can however develop considerable expertise in a given specialty under proper supervision and can provide many services under the direction of the supervising physician.

What can PAs do?

PAs obtain medical histories, conduct physical examinations, diagnose and treat illnesses, prescribe medicines, order and interpret lab tests, perform procedures, assist in surgery, provide patient education and counseling and make rounds in hospitals and nursing homes. Dr. Marshall has very specific written agreements with his physician assistants detailing both medicines that can be prescribed and minor procedures that can be performed. A copy of this agreement is available upon request.

How are PAs supervised?

Ideally a PA practices under the direct supervision of a physician in the office. In an effort to improve access to care, Idaho has somewhat liberal laws regarding how PAs must be supervised. At a minimum Dr. Marshall reviews 10% of the medical charts generated by his physician assistants. When he is not in the office with a physician assistant who is seeing patients, he is always available by phone even if it's a satellite phone at times.

How should I address a PA?

Since a PA is not a physician, the title of "Doctor" is inappropriate. As informal as it may seem, the proper way to address a PA is by their first name or by PA (Last Name).

Can I choose to see Dr. Marshall instead?

As a patient you are ultimately responsible for whom you choose to provide your health care. At Alpine Dermatology front desk personnel are instructed to offer patients appointments with Dr. Marshall first, but due to availability issues you may choose to see a PA. The bottom line is that you can choose to make your appointment with Dr. Marshall if that's your preference.

I hereby acknowledge that I have read and understand the above information and have been given an opportunity to ask questions as it relates to my care at Alpine Dermatology Clinic. I further acknowledge that when I see a physician assistant at Alpine Dermatology I am not seeing a "doctor," nor a "dermatologist," nor a "specialist," but that I am seeing a physician assistant who has developed additional expertise in the field of dermatology and is practicing under the proper supervision of a board certified dermatologist.

Signature: _____ Date: _____