# Dermatology-Dermatologic Surgery- Aesthetic and Cosmetic Dermatology

Name: _____Preferred Name: _____Sex: M/F____DOB: _____

SS# :_____Marital Status: ____ Primary Care Phy:_____ Referred By: _____

Street Address: _____City/State: _____Zip Code:_____

Cell # :_____ Text reminder? Y____N____ Home#: _____

Best way to contact (circle one): Cell Phone/ Home Phone/ Email How did you hear about us?_____

Email Address: _____@_____

Preferred Language: _____ Race: _____ (Circle One): Ethnic Group: Hisp/Latino or Non Hisp/Latino

Preferred Pharmacy _____ City _____ Phone#:_____

INSURANCE COMPANY: _____ Relationship to insured (circle one): Self / Spouse / Parent

Although we accept Aetna, BlueCrossBlueShield (not BlueLincs), FirstHealth, HealthChoice Humana, and Medicare. You are expected to pay a yearly unmet deductible or co-pay at each visit**.** Aetna-HMO & Humana-HMO require your primary doctor's referral dated on or before your visit. Insurance companies return explanations of benefits and payments to you 5-7 days before we get them.

For products or procedures, a separate payment is due at the time of your visit. These charges are subject to your annual surgical deductible and are due prior to your visit. Please advise receptionist before your visit if you arrive without the ability to pay. We will be happy to reschedule you.

Medicare patients: your annual deductible of $183 is due at your first visit of the year, whether or not your secondary insurance paid it last year. This is because policies for many of them have changed. Items **usually not** covered by insurance: cysts, hair loss, skin tags, warts (unless bleeding), skin products, and fillers.

Prescriptions are refilled only if you have been seen within the past 90 days and the account is up to date. **A $30 service fee is charged for: returned checks. The fees will be added to your account.**

I understand and accept the above office policies. I am responsible for the payment of all professional and administrative fees incurred by myself or my dependents at this office regardless of insurance that I may have. I give permission for Dr. Graham and his associates to treat me or my minor child. I authorize my insurance benefits to be paid directly to Graham Dermatology Center or Silver Leaf Dermatology. I authorize Graham Dermatology Center or David Graham, M.D. to release any information to my insurance company upon my written request, and to charge my credit card for any unmet deductibles that are due, either upon receipt of advice from my insurance company, or phone requests from us. This avoids a billing fee.

For questions with any of the above, please ask our staff for assistance prior to visit. To put your payment or unmet deductible on CareCredit®, please notify the receptionist.

Signature:_____ Date:_____

# Intake and History Form

## Past Medical History

**Select any of the following medical conditions you currently have:**

- ☐ Acne Scarring
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____
_____
_____

## Past Surgical History

**Have you had any surgeries on the following organs?**

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy

- [ ] Skin: Squamous Cell Carcinoma
- [ ] Spleen (Splenectomy)
- [ ] Testicles (Orchiectomy)
- [ ] Uterus (Hysterectomy): Fibroids
- [ ] Uterus (Hysterectomy): Uterine Cancer
- [ ] Uterus (Hysterectomy): Cervical Cancer
- [ ] NONE
- [ ] Other

_____
_____
_____

## Skin Disease History

**Have you had any of the following?**

- [ ] Acne
- [ ] Actinic Keratosis
- [ ] 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
- [ ] NONE
- [ ] 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?**

◯ Yes ◯ No

If yes, which relative?

- [ ] Mother
- [ ] Father
- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Aunt
- [ ] Nephew
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Grandson
- [ ] Granddaughter
- [ ] Other

_____
_____

# Intake and History Form

## Medications

List all current medications:

_____

_____

_____

## Allergies

List all allergies to medications and reactions if known:

_____

_____

## Social History

**Smoking Status (please choose one):**

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____
Total Years Smoking: _____

**Alcohol Intake (please choose one):**

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

**How often do you exercise?**

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

**What is your caffeine use?**

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

## Family History

Please include only first-degree relatives with skin conditions:

_____

_____

## Silver Leaf Dermatology – David L. Graham, M.D.

307 E Danforth Ste 154 Edmond, OK 73034

### Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided Silver Leaf Dermatology's (SLD) Notice of Privacy Practices. It tells me how SLD will use my health information for the purpose of my treatment, payment for my treatment, and SLD's health care operations. The notice explains in more detail how SLD may use and share my health information for other than treatment, payment, and health-care operations.
SLD will also use and share my health information as required by law.

Patient's complete Legal Name:_____
Patient's SSN:_____Patient's DOB:_____
Signature:_____Date:_____
(Patient or legal representative* May be required to show proof of representative status)

Rev 03/15/17 File in Chart HIPAA Document Retain for minimum 6 years

**SILVERLEAF DERMATOLOGY /GRAHAM DERMATOLOGY CENTER**

Welcome to our practice! Early detection of melanoma is of utmost importance. It is usually curable if found early. Later, it may require chemotherapy, which is often not very effective.
In 20% of cases, melanoma is found in unexposed areas, and can arise from atypical moles or normal skin. Many skin lesions change through time, initially appearing normal and later becoming malignant. The American Academy of Dermatology and the National Cancer Institute recommend that all fair-skinned people have full-body exams yearly and more often if they have a history of atypical moles or melanoma.
To determine whether you have lesions or moles needing evaluation, a full body exam is required. A female assistant is present when covered areas are examined in female patients.
Full body exams are scheduled at the end of your first visit, unless you or a close relative is concerned about a particular lesion. If so, please inform the doctor as more time is required. An additional fee may apply.

## Sign Below

_***X***__ *Full body exam, if time permits. (On file for future visits if not in relation to today)*

Signature: _____Date:_____

**PAYMENT POLICY**

For your convenience, we attempt to verify your benefits before your visit, and request your co-pay at the time of check-in. This allows us to focus on your care. We bill most insurance companies if an electronic payor number is shown on your card. If we later need to bill you because of an unmet deductible or lapse in coverage, the staff will call you to resolve the issue.

New patient appointments are either $150 or $200 depending on the length and complexity of the visit. If there are any additional charges, we will advise you in advance. Follow-up visits are a standard $100 per appointment. For additional credit, please inquire about our Care Credit. If you have suffered recent or severe financial hardship, please advise our staff, and an adjustment can be arranged.

Products and cosmetic procedures are paid separately and not billed to insurance. Products are refundable within 30 days if returned by you in person.

**For surgical procedures, a 20% deposit (or copay) is required due to limited availability. Deposits are only refundable with a 24 hours' notice, unless you have a true emergency.**

Specimens are submitted to D-Path for testing which may incur additional fees billed only by them.

If your insurance company's explanation of benefits (EOB) later shows your share is less than the amount paid at your visit, we will promptly refund you the difference by account credit, credit card, or check within ten business days of our office being notified. Please fax your copy of the EOB to us at 405.216.0145 with a note indicating your refund preference type.

**Please note: Providing excellent care to you is of greatest importance to us. We strive to make your visit a positive and valuable one. If you are not happy with your visit, please contact us immediately in person, email, or by phone so we may resolve the matter. We will work with you to achieve your full satisfaction. If for any reason the staff cannot resolve your concerns, please contact the doctor directly by email at silverleafderm@yahoo.com. If you have not received a response back within 24 hours, please give us a call.**

I have read and have no further questions and wish to proceed with the visit based on above.

Signature:_____ Date:_____

Name(Printed):_____