DERMATOLOGY MEDICAL HISTORY

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name:_____ **Date of Birth:** ____/____/_____

Last *First* *M.I.*

Reason For Today's Visit_____

MEDICATION: List all medications. Include prescriptions, over-the-counter, vitamins, and herbals.

_____ _____ _____

_____ _____ _____

ALLERGIES: List any allergies to medications.

_____ _____ _____

Have you ever had dental anesthesia (Novocaine)? ☐ **YES** ☐ **NO** Bad reaction? ☐ **YES** ☐ **NO**

DISEASES/CONDITIONS: Check all that apply.

LUNGS
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Pacemaker
- ☐ Phlebitis

DISEASES OF THE:
- ☐ Ear, Nose, Mouth, Throat
- ☐ Eye
- ☐ Kidney/Bladder
- ☐ Thyroid

MENTAL HEALTH
- ☐ Stress, Anxiety
- ☐ Depression
- ☐ OCD

OTHER SYSTEMIC:
- ☐ Arthritis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diabetes
- ☐ Fainting
- ☐ Fever/Chills/Night Sweats
- ☐ Seizures
- ☐ Weight Loss

☐ **NONE OF THE ABOVE CONDITIONS APPLY**

List any other diseases or conditions:_____

List any major surgical procedures:_____

Are you pregnant? (Women) ☐ **YES** ☐ **NO** If YES, Due Date: ____/____/_____

SKIN: Check all that apply.

- ☐ Bleed Easily
- ☐ Develop Keloids After Surgery
- ☐ Problems Healing
- ☐ History of Skin Cancer
- ☐ Family History of Skin Cancer
- ☐ Recurrent Skin Infection
- ☐ History of Specific Skin Disease(s)_____
- ☐ Skin Rashes in Reaction to:☐ Medications ☐ Food ☐ Environment ☐ Bandages☐ Other:_____

SOCIAL: Check all that apply.

- ☐ Drink Alcohol If YES, _____ Drinks Per Day
- ☐ Smoke If YES, _____ Packs Per Day
- ☐ Use IV Drugs If YES, What and How Often: _____
- ☐ Been Exposed to HIV (AIDS)

Who is your Primary Care Physician?_____ Referred By:_____

What is your occupation?_____ Hobbies?_____

Patient or Responsible Party Signature:_____ **Date:**____/____/_____

Bikowski Skin Care Center

CONSENT FOR USE OR DISCLOSURE OF INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (HIPAA)

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Bikowski Skin Care Center in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Bikowski Skin Care Center Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form.

Bikowski Skin Care Center reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Bikowski Skin Care Center does change the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requisitioning the Notice from the Front Office Staff of Bikowski Skin Care Center.

I retain the right to request that Bikowski Skin Care Center further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Bikowski Skin Care Center is not required to agree to such requested restrictions; however, if Bikowski Skin Care Center does agree to my requested restriction(s), such restrictions are then binding on Bikowski Skin Care Center.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Bikowski Skin Care Center in writing. The revocation shall be effective *except* to the extent that Bikowski Skin Care Center has already taken action in reliance on the consent. *Bikowski Skin Care Center may refuse to treat you, if you do not sign this Consent Form* (except to the extent that Bikowski Skin Care Center has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

PHONE CONSENT: I AUTHORIZE THE PHYSICIANS AND STAFF OF BIKOWSKI SKIN CARE CENTER TO:

Leave a message on my answering machine or voice mail at home? ___Yes ___ No Tele#_____
Leave a message on my cell phone? ___Yes ___ No Tele#_____
Text message my cell phone? ___Yes ___ No Tele#_____
Leave a message at my place of employment? ___ Yes ___No Tele#_____
Discuss my medical condition with a member of my family or a friend? ___ Yes ___No Tele#_____

If yes, please print names: _____ Relationship_____
_____ Relationship_____
_____ Relationship_____

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ ____/_____/_____ Date_____/_____/_____
Signature of Patient Date of Birth

_____
Please Print Name

_____ _____ _____
Signing on behalf of Patient Please Print Name Relationship to Patient

CONSENT FOR MINOR TO PRESENT FOR TREATMENT
(If a patient is under 18 - A parent or Guardian must sign)

I,_____, give my consent for my son/daughter, _____

_____ to bring himself/herself to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's signature_____ Date_____

Witness_____ Date_____

Bikowski Skin Care Center

AUTHORIZATIONS AND CONSENTS FOR PRECERTIFICATION, FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND RELEASE OF CLAIMS INFORMATION

Precertification & Financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that this includes any pathology charges that may be incurred. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Bikowski Skin Care Center, all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to Bikowski Skin Care Center. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and Bikowski Skin Care Center.

Authorization to Release Claims Information: I hereby authorize Bikowski Skin Care Center, their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits by or on behalf of any such person. I hereby authorize Bikowski Skin Care Center, its employees and agents to act on my behalf in completing claims.

I HAVE READ AND FULLY UNDERSTAND THE PRECERTIFICATION & FINANCIAL RESPONSIBILITY AUTHORIZATIONS, ASSIGNMENT OF BENEFITS CONSENTS AND AUTHORIZATION TO RELEASE CLAIM INFORMATION PRINTED ON THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM. THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: _____ Date: _____/_____/_____

Patient's Printed Name: _____

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is as follows:

Signature of Authorized Representative: _____

Relationship to Patient: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____