44 South Kintner Parkway, Suite B
Sunbury, OH 43074

Ohio Premier Dermatology

Phone: (740) 965–0855
Fax: (740)965-0836

Name Last First MI	**Preferred Name**	**Age**	**Date**
SSN	**Sex** □ Male □Female	**Birth Date** / /	**E-mail** - if provided, you are allowing us to send you information via E-mail
Address	**City**	**State**	**Zip**
Primary Phone □ Cell □ Home	**Alternate Phone** □ Cell □ Home	**Work Phone (no messages will be left)**	

Message Preference: ☐ **Leave Messages** ☐ **Do Not Leave Messages**
I hereby give permission to Ohio Premier Dermatology to notify me by telephone of any appointments, message to call the office for test results (actual results will not be left) and other medical or cosmetic information.

Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Other □ Minor Child (under 18 years of age)

How did you hear about this practice? □ Office Sign □ Was a previous patient □ Ad □ Internet □ Billboard
□Doctor__________________ □ Family/Friend________________________ □ Other___________________________

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino

Language: What is your preferred language? ☐ English Other ________________

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Pacific Isle/Hawaiian Native □ Other

Patient's Employer Name & Address:	**Occupation:**

If patient is a student, name of college/school:

□ Spouse □ Partner □ Parent (if patient is under 18)

Name	DOB:	Employer:

Primary Care Physician:	Phone:
Address:	

Pharmacy Name:	Address:	Zip Code:
Emergency Contact Name:	Relationship	Phone:

By signing here you give permission for your child, at least 16 years of age, to be seen without a guardian present.

Parent Name: ______________________________ **Signature:** _________________________________ **Date:** ________________

Primary Insurance Information: Guarantor (Person for plan whom insurance is under)			**Secondary Insurance Information: Guarantor (Person for plan whom insurance is under)**		
Name of Guarantor:			Name of Guarantor:		
Relationship to patient: □ Self □ Spouse/Partner □ Parent			Relationship to patient: □ Self □ Spouse/Partner □ Parent		
SSN	Birth Date	Copayment: $	SSN	Birth Date	Copayment: $
Insurance Co.			Insurance Co.		

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

___________________________________ ______________________________ _______________

Patient/Guardian Signature **Patient/Guardian Name Printed** **Date**

MEDICAL QUESTIONNAIRE

Medication

List ALL medications you are currently taking (including prescriptions, over the counter medications, vitamins, herbal supplements):

1.________________________________ 2.________________________________ 3.__________________________________

4.________________________________ 5.________________________________ 6.__________________________________

(Please use a separate sheet for additional medications)

Do you have any of the following?

Emphysema □Yes □No	Congestive Heart Failure □Yes □No	Heart Murmur □Yes □No
Asthma □Yes □No	Irregular Heartbeat □Yes □No	Mitral Valve Prolapse □Yes □No
Tuberculosis □Yes □No	High Blood Pressure □Yes □No	Pacemaker /Defibrillator □Yes □No
Diabetes □Yes □No	Stomach Ulcers □Yes □No	Anemia □Yes □No
Lupus □Yes □No	Arthritis □Yes □No	Artificial Joint(s) □Yes □No
Auto Immune Disorder □Yes □No	Depression □Yes □No	HIV/AIDS □Yes □No
Liver Disease □Yes □No	Other Mental Health □Yes □No	Hepatitis □Yes □No
Kidney Disease □Yes □No	Thyroid Disease □Yes □No	Have you ever been diagnosed with MRSA? (Methicillin Resistant Staph) □Yes □No

Please list any allergies:

____

____

____

____

Social History:

Do you smoke? □ Yes □ No How much: _______ Do you drink alcohol? □ Yes □ No ___ per day/week/mo.

Do you use recreational drugs? □Yes □No What type ___________________________

History of past IV drug abuse, blood transfusions, or unprotected intercourse: □ Yes □ No

Are you interested in any Cosmetic Dermatology? □ Yes □ No If yes, please check which one

□ Skin Care Products	□ Chemical Peels	□ Age Spots
□ Sun Damage Skin Care	□ Botox/ Dysport	□ Excessive hair
□ Aging Skin	□ Fillers (Perlane, Restylane)	□ Laser for red spots or Rosacea
□ Skin Pigmentation	□ Mole Removal	□ Laser Tattoo Removal
□ Short Eyelashes	□ Skin Tag Removal	□ Laser Hair Removal
□ Sclerotherapy (for spider veins)	□ Scaring	□ Laser Resurfacing

In a few words explain why you are being seen today:

____

____

____

Full Body Skin Exam: It is recommended you have a yearly full body exam for the detection and treatment of skin cancer. When scheduling this appointment please specify the appointment is for a full body exam as extra time is needed.

Completed by: □ Patient □Patient's Parent □ Guardian □ Other _________________

_______________________________ _______________________________ _______________

Patient/Guardian Signature **Patient/Guardian Name Printed** **Date**

Patient Name: ____ Date of Birth: ___/___/____

(PRINT)

Ohio Premier Dermatology adheres to the following HIPAA guidelines set forth by the United States Department of Health and Human Services and the Office for Civil Rights. You have the right to receive, and we are required to provide you with a copy of the Notice of Privacy Practices (NPP). Below is a brief outline of the policies, but you are encouraged to read the full version.

HIPAA

The patient listed above or the legal representative of the patient listed above understands:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment, health care operations, when required by law enforcement and for other legitimate reasons.
- We may contact you by phone, e-mail or in writing, to provide appointment reminders or information about treatments or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving marketing and fundraising communications from us.
- Reminders of upcoming appointments may be left on an answering machine or with a family member.
- You have the right to request an alternative means of confidential communication.
- Your PHI will not be sold by Ohio Premier Dermatology
- You have the right to inspect, copy, restrict and amend your PHI or revoke prior authorizations in writing.
- You have the right to restrict disclosures of PHI to a health plan if the office visits or services were paid “out of pocket”, in full and in advance or at the time of the visit.
- You have the right and will be advised if your PHI is intentionally or unintentionally disclosed.
- Uses and disclosures of PHI not described in the NPP will be made after written authorization form the patient
- Notification regarding the availability of pathology or laboratory results may be left on an answering machine or with a family member BUT the actual results WILL NEVER be left to anyone other than the patient or family member(s) listed below.

Authorization for Disclosure of Medical Records

I authorize the disclosure of any of my medical records to the following individual(s):

1. ______________________________ ______________________ ______________________
   Name Relationship Phone
2. ______________________________ ______________________ ______________________
   Name Relationship Phone

Financial and Privacy Policy

One of our main goals here at Ohio Premier Dermatology is providing the best care and service with maximum satisfaction. For a better understanding of our financial and privacy policies, we have provided you with a copy of the practice’s guidelines that we expect all patients to abide by.

By signing I hereby acknowledge receipt of Ohio Premier Dermatology’s Notice of Privacy Practices, Financial and Practice Policies. I agree and will adhere to them when applicable.

This consent was signed by: X______________________________________ Date: ____/____/____

(Signature of Patient or Legal Representative)

Updated: 9/23/2013