Name:_____**Date of birth:**_____**Social security:**_____
Address:_____**Home phone:**_____**Cell phone:**_____
Marital status: S M D W **Emergency contact name and number:**_____
Email address:_____**Authorized to release information to:**_____
Can we leave you a detailed voice message: YES NO **City and state of birth:**_____
Occupation:_____**Employer:**_____**Industry:**_____
Primary Care Physician:_____**Primary care phone:**_____
Pharmacy name:_____**Pharmacy Address:**_____
Race: White Native American Asian African American Unknown
Other:_____ **Language:**_____ **Ethnicity:** Hispanic or Latino

Allergies:_____**None:**

MEDICAL HISTORY: Please CIRCLE all that apply **NONE**

Anxiety	COPD	HIV / AIDS
Arthritis	Coronary Artery Disease	Hypercholesterolemia
Asthma	Depression	Hypertension
Atrial Fibrillation	Diabetes	Hyperthyroidism (overactive)
BPH	End Stage Renal Disease	Lymphoma
Hypothyroidism	Bone Marrow Transplantation	GERD Leukemia
Breast Cancer	Hearing Loss Lung Cancer	
Colon Cancer	Hepatitis	
Prostate Cancer	Radiation Treatment	
	Seizures Stroke	

Smoking: Current Never Former **Alcohol:** None 0-1 drinks per day 1-2 drinks per day 3 or more drinks per day

PAST SURGICAL HISTORY: (please circle all that apply) **NONE**

Appendix (Appendectomy)	Bladder (Cystectomy)	Heart: PTCA (Angioplasty)
Breast: _____	Colon: _____	Kidney Transplant
Heart: Coronary Artery Bypass (CABG)	Ovaries Removed: Cancer	Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement	Heart Transplant	Uterus (Hysterectomy): Fibroids
Ovaries Removed: Endometriosis	Uterus (Hysterectomy): Uterine Cancer	Knee Replacement: (Right, Left, Bilateral)
Kidney Removed: (Right, Left)	Kidney Stone Removal	Hip Replacement: (Right, Left, Bilateral)
Ovaries Removed:	Cyst Prostate Removed: Cancer Prostate Biopsy	Prostate: TURP
Gallbladder Removed	Skin Biopsy	Surgery Skin: Melanoma
Skin: Basal Cell Carcinoma	Surgery Skin: Squamous Cell Carcinoma	Spleen Removed
Testicles Removed (Right, Left, Bilateral)	Other Important Surgical History:_____	

SKIN DISEASE HISTORY: **NONE**

Acne	Flaking Or Itchy Scalp	Warts	Dry Skin
Actinic Keratosis	Squamous Cell Skin Cancer	Impetigo	Precancerous Moles
Basal Cell Skin Cancer	Melanoma	Eczema	Kaposi scar
Blistering Sunburns	Other infection	Poison Ivy	Psoriasis Other:
Nail disorder	Allergic reactions	Cold Sores	Hair loss
Keloid scar			

Basal cell carcinoma or Squamous cell carcinoma :

Year:_____Location:_____Treatment:_____

Year:_____Location:_____Treatment:_____

Melanoma: Year:_____Location:_____Treatment:_____

Do you wear Sunscreen? Yes No **What SPF?** _____

Do you have a family history of <u>Melanoma</u>? Yes No Who? _____

Signature:_____ Date: _____

Name: _____

CO-PAYMENT AND DEDUCTIBLES

Payment is required for all services at the time they are rendered. Co-payments will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. I further acknowledge that I am responsible for the co-insurance and/or deductible under my health plan's agreement and should my account be sent to a collection agency, I shall be responsible for the collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy.

REFERRAL POLICY

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and ensure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, I will need to reschedule my appointment.

INSURANCE CARDS

All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

CANCELLATION POLICY

Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 24 hours prior to the appointment will result in a $25.00 no-show fee. This fee is not reimbursable by your insurance company.

Patient Signature:_____Date: _____

HIPAA POLICY

Patients 18 years of age or older are protected under the Federal **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct. This federal law prohibits any staff member of **Connolly Dermatology** from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition or obtain results for you, please list their name(s) below. Only individuals whose names are listed will be provided with information. Should you wish to update the names provided, please ask the receptionist at the front desk for a HIPPA form.

Name of Individual (please print) _____

_____

Relationship to Patient _____

Name of Individual (please print) _____

_____

Relationship to Patient _____

If we are unable to reach you may we leave a message on voicemail? YES NO

If we are unable to reach you may we leave a message with a person? YES NO

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review the Notice of Privacy. I understand a copy of the Privacy Practices is available upon my request).

Patient Signature:_____Date: _____

Must be signed by patient 18 years or older. Patients under 18, must be signed by a parent or legal guardian.

COSMETIC INTEREST QUESTIONNAIRE

Name: _____ Date: _____

Email Address:_____

Health issues and procedures or products of interest to you (please check all that apply).

- ❑ Free Visia Complexion Analysis
- ❑ Micro-Dermabrasion
- ❑ Chemical Peels
- ❑ Facial and Eye Treatments
- ❑ BOTOX®
- ❑ Juvederm®
- ❑ Skin Care Advice -
- ❑ Sunscreen Advice
- ❑ Skin Care Products
- ❑ Cellulite Therapy
- ❑ Acne Products
- ❑ Anti-aging Products
- ❑ Other, please specify _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	*2*	*3*	*4*	*5*

How did you hear about us?

- ❑ My physician (full name) _____
- ❑ An advertisement (please specify) _____
- ❑ A friend or family member (name) _____
- ❑ Another person not listed above (name) _____

Please provide the name of and address of the person who referred you so we can thank them.

_____

- ❑ *Internet*
- ❑ *A seminar where I saw a physician. The event took place on (date) _____ at (location) _____.*

Patient Name:_____

Primary Care Physician (PCP):
_____

Patient DOB:_____

Date:_____

Pharmacy Name:_____

Address:_____

Phone Number:_____

Medications/Supplements List

Drug/Vitamin Name	Dosage	Frequency	Administration (ex: oral, injection)
Allergies			

NO MEDICATIONS/ALLERGIES

CONNOLLY DERMATOLOGY

Provider Signature:_____
Date:_____

HIPAA Patient Consent Form

This notice of Privacy Practices describes how we may use and disclose your health information to carry out treatment, payment or health care operations and any other purposes that are permitted or required by law. It describes your right to access and control your protected health information. "Protected health information" is any information about you, including demographic information, that may identify you and relate to your past, present or future health or condition and related services.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by Connolly Dermatology, our office staff and anyone that is involved in your care and treatment for the purpose of providing health care service to you, to pay your health care bills, to support the operations of the physician's practice, and any other use required by law. These uses may include, but are not limited to, coordinating or managing your health care and related services with a third party, to obtain payment for your health care services, staff training purposes, to contact you to remind you of your appointment, using a sign in sheet at the registration desk and calling you by name in the waiting room when your provider is ready to see you.

OTHER USES AND DISCLOSURE WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION:

We may use or disclose your protected health information in the following situations without your authorization. These situations might include: as required by law, public health issues as required by law, communicable diseases, abuses or neglect, FDA requirements and any matter required by law.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information complied in reasonable anticipation of, or use in a civil criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request my state specific restrictions requested and to whom the restrictions apply. Connolly Dermatology is not required to agree to a restriction request.

COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager. If you have any objections to this form, please ask to speak with our Office Manager.