SKIN SURGERY CENTER of OKLAHOMA | MOHS SURGERY AND DERMATOLOGIC SURGERY

MEDICAL HISTORY AND INTAKE FORM

Patient Name: _____ **Date of Birth:** (MM/DD/YYYY): _____

RACE

- ❍ American Indian or Alaskan Native
- ❍ Asian
- ❍ Black/African American
- ❍ Native Hawaiian or Other Pacific Islander
- ❍ White
- ❍ Other Race_____
- ❍ Decline to specify

ETHNIC GROUP

- ❍ Hispanic
- ❍ Latino
- ❍ Not Hispanic or Latino
- ❍ Unknown
- ❍ Decline to specify

PREFERRED LANGUAGE

- ❍ English
- ❍ Other_____
- ❍ Decline to specify

Where were you born? (State and Country): _____

Who is your Primary Care Physician? (Name and Phone Number):

_____

What is the name of the Physician who referred you to our clinic? (Name and Phone Number):

_____

Do you have a living will? ❍ **Yes** ❍ **No**

Our Providers participate in E-Prescribing. Please provide the following information:

Pharmacy Name: _____ **Phone Number:** _____

Pharmacy Address: _____

_____

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

❍ None	❍ COPD	❍ End Stage Renal Disease	❍ Lymphoma
❍ Atrial Fibrillation	❍ Coronary Artery Disease	❍ Immunosuppression	❍ Radiation Treatment
❍ CVA-Stroke	❍ Diabetes	❍ Leukemia	

PAST SURGICAL HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

- ❍ None
- ❍ Basal Cell Cancer Surgery
- ❍ Melanoma Surgery
- ❍ Squamous Cell Cancer Surgery
- ❍ Shoulder Joint Replacement (Right, Left, Bilateral) Date_____
- ❍ Knee Joint Replacement (Right, Left, Bilateral) Date_____
- ❍ Hip Joint Replacement (Right, Left, Bilateral) Date_____
- ❍ PTCA (angioplasty, heart stent)
- ❍ Biological Heart Valve Replacement
- ❍ Mechanical Heart Valve Replacement
- ❍ Pacemaker/Defibrillator
- ❍ Heart Transplant or other Organ Transplant
- ❍ Other_____

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Patient Name: _____

SKIN DISEASE HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

❍ None	❍ Dysplastic nevus of skin (precancerous moles)	❍ Squamous Cell Skin Cancer
❍ Actinic Keratosis (AK's)	❍ Melanoma	❍ Other_____
❍ Basal Cell Skin Cancer	❍ Psoriasis	

Do you wear Sunscreen? ❍ **Yes** ❍ **No** **If Yes, what SPF?**____ **Do you tan in a tanning salon?** ❍ **Yes** ❍ **No**

Family History of Melanoma? ❍ **Yes** ❍ **No**

If yes, whom: _____

MEDICATIONS: (ALL CURRENT MEDICATIONS INCLUDING NON-PRESCRIPTION AND BIRTH CONTROL; IF NONE, MARK N/A)

_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION OR LATEX ALLERGIES: (PLEASE LIST ANY ALLERGIES THAT YOU HAVE, AND THE REACTION YOU HAD. IF NONE, MARK N/A)

SOCIAL HISTORY:

❍ Non-Smoker ❍ Former Smoker ❍ Current Smoker

Alcohol: ❍ None ❍ 1 or less per day ❍ 1-2 per day ❍ 3 or more per day IV Drug Use:_____

REVIEW OF SYSTEM:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Swollen Lymph Nodes			Do you have a Pacemaker?		
Pregnant or currently trying to become pregnant			Do you have an Artificial Heart Valve?		
Changing Moles; Other than primary reason for visit			Have you had Artificial Joint Surgery in the past 2 years?		
Problem with Healing			History of Rapid Heart Beat with Epinephrine?		
Chest Pain			Are you taking Blood Thinning Medication?		
Shortness of Breath			Do you have a history of Bleeding Disorders?		
Cough			Do you require Antibiotics prior to procedures?		
Unintentional Weight Loss			History of Allergy to Band Aids or Adhesive Tape?		
Fever or Chills			History of Keloid or Hypertrophic Scarring?		
Headaches			History of MRSA (Resistant Staph Infections)?		
Anxiety			Do you have HIV/AIDS?		
Do you have a Defibrillator?			Do you have a history of Hepatitis B or C?		

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PATIENT INFORMATION

PATIENT'S LEGAL NAME:

First: Middle: Last: Gender:

DATE OF BIRTH: **SOCIAL SECURITY NUMBER:** **MARITAL STATUS:**

MAILING ADDRESS: Street City State Zip

Email Address: **Employer:** **Job Title:**

Home Phone: **Cell Phone:** **Work Phone:** *(please circle primary contact number)*

PARENT OR LEGAL GUARDIAN (IF APPLICABLE):

I understand the practice may use the information I provide to contact me regarding my treatment and payment, including through voicemail messages, text messages and email, and for appointment reminders, billing matters and test results (for benign test results, a message may be left. I understand I can revoke this authorization at any time in writing to the practice.

INSURANCE PARTY INFORMATION ***COPAYMENTS AND DEDUCTIBLES ARE EXPECTED AT TIME OF SERVICE

Primary Insurance	Policy Holder's Name	Policy Holder DOB/Relationship to Patient
Secondary Insurance	Policy Holder's Name	Policy Holder DOB/Relationship to Patient

EMERGENCY CONTACT

I authorize for the practice to contact the following person as my emergency contact:

Name	Relationship	Phone Number

RELEASE OF MEDICAL RECORDS INFORMATION

Additionally, I voluntarily and at my discretion authorize the practice to verbally discuss my scheduling/appointment information, billing and payment information, prescriptions, and refills, laboratory and test results (except HIV or genetic testing), and medical information (but not mental or behavioral health information), including my symptoms, diagnosis, medications and treatment plans with the below persons, I understand I have the right to revoke this consent, in writing, except where the practice has already made disclosures in reliance on my prior consent. I understand that I am responsible for notifying the practice if there are changes to those that may participate in in my care. This form does not authorize releasing copies of my medical records to the persons below.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature	Date

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FINANCIAL POLICY, CONSENT, AND HIPAA ACKNOWLEDGEMENT

Patient Name: _____ **Date of Birth**: _____

- **Agreement for Services:** I agree to the services that may be performed by Skin Surgery Center of Oklahoma physicians and non-physician providers. I understand I can withdraw from this agreement at any time. I understand that except in an emergency, no major procedure or treatment will be performed without providing me an opportunity to give informed consent, meaning the provider will first provide me with information including the nature of the procedure or treatment, risks, benefits and alternatives.
- **Insurance Billing:** I consent for the practice to bill my insurance company according to the most recent insurance information and insurance card(s) including, Medicare and Advantage Plan cards, that I have provided. I understand that all payment of all balances is my responsibility, including copays, co-insurance amounts, deductible amounts and services that are not covered by my insurance plan (such as cosmetic services). I understand that if claims are denied due to lack of current insurance information, I will be responsible for the balance.
- **Insurance Network:** I understand that it is my responsibility to ensure that this practice and the provider of services are in my insurance network. If my plan requires a referral from my PCP, it is my responsibility to obtain the referral. If my claim is denied because I am out of network or failed to obtain a referral, I understand that I will be responsible for the balance.
- **Co-payment:** I understand all co-payments must be paid at the time of service. I understand co-payment and co-insurance are determined by my insurance. The practice accepts cash, check, Visa, MasterCard, American Express, Discover and Care Credit.
- **Deductible:** An annual deductible is the dollar amount I must pay out of pocket during the year for medical expenses before my insurance begins to pay.
- **Images and Monitoring:** I understand that the Skin Surgery Center of Oklahoma may make and use photos or other images for identification, diagnosis, treatment, performance improvement and education purposes. I consent to such images with the understanding that any images are not readily available to visitors or the public and will not be disclosed except as required or permitted by law.
- **Self-Pay:** I understand and agree that if I do not have insurance or opt out of Insurance coverage if permitted and elect to be seen as a self-pay patient, I have full financial responsibility for my visits and will pay for all services at the time of service, unless other arrangements have been made. I understand I will be subject to and will abide by the practice's self-pay policy. This agreement will remain in effect unless proof of insurance is provided at a subsequent date.
- **Pathology Processing Charges:** I understand that any biopsy or removal of lesions performed during my office visit will be sent to an outside pathology lab for processing. All charges and billing for these services will be processed by the lab. These charges are separate from my visit at Skin Surgery Center of Oklahoma, and I understand that I will receive a separate statement from the lab.
- **Past Due Balances:** I understand that if my account is over 90 days past due, this practice will send a statement and I will have 20 days in which to pay the balance in full. Partial payments will not be accepted unless previously negotiated. I understand that if the balance remains unpaid this practice may refer my account to a collection agency and/or I may be dismissed from this practice.
- **Late Arrivals or Missed Appointments:** I am aware that if I am late to my appointment I may be rescheduled. I also understand that multiple missed appointments without adequate notice and/or late arrivals may result in my dismissal from the practice. If I am unable to keep my appointment, I will notify this office at least 24 hours in advance.
- **HIPAA Disclosure and Notice of Privacy Practices:** I consent for this practice to release information to my insurance company, primary care/referring physician, and any other covered entities in accordance with the HIPAA Privacy Act. I understand that medical information disclosed may be used and forwarded to provide continuing treatment or care, for filing claims, and for all other healthcare operations. I have received this practice's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have had the right to review such notice prior to signing this consent form.
- **This form applies to The Skin Surgery Center of Oklahoma and its related companies.**

My signature indicates that I have been given the opportunity to review this information, ask questions and have had my questions answered. I understand that I am financially responsible for all services as described in this consent form.

_____ _____

Patient Signature Date