DERMATOLOGY CENTER OF THE ROCKIES **-Dermatology Health History-**

Patient: ______________________ **Date of Birth:** ______________

REASON FOR TODAYS VISIT: ____________________________________

REQUIRED *(if no primary care physician, please write NONE)*

Primary Care Physician Full Name: ______________ **Preferred Pharmacy:** ______________

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	Yes	No		Yes	No
Anemia	☐	☐	Have you had Accutane Treatment?	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐
Artificial Joint	☐	☐	Hepatitis: Type: ______	☐	☐
Asthma/Hay fever	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	HIV/AIDS	☐	☐
Blood Clots	☐	☐	Irregular Heartbeat	☐	☐
Blood Transfusion	☐	☐	Kidney	☐	☐
Cancer: Type: ______	☐	☐	Liver Disease	☐	☐
Chest Pain	☐	☐	Mental Health	☐	☐
Diabetes	☐	☐	MVP Mitral Valve Prolapse	☐	☐
Emphysema	☐	☐	Organ Transplant	☐	☐
Epilepsy, Seizures, Fainting	☐	☐	Pacemaker	☐	☐
Fever Blisters / Cold Sores	☐	☐	Radiation Treatments	☐	☐
Gastrointestinal	☐	☐	Stroke	☐	☐
Heart Attack	☐	☐	Thyroid	☐	☐

☆WOMEN☆ ☐ Pregnant ☐ Breastfeeding ☐ Trying to get pregnant

List any other diseases, conditions, surgeries or hospitalizations: ______________

Have you ever had any of the following? ☐Actinic Keratosis ☐Melanoma ☐ Basal Cell
☐ Squamous Cell ☐Unusual moles ☐Blistering Sunburns ☐Psoriasis ☐Eczema
☐Excessive Scarring ☐ Keloids ☐Severe Acne ☐Other ______

Are you allergic to Latex? ☐ Yes ☐ No

Allergies to Medications: ____________________________

All Medications (prescription and non-prescriptions): ____________________________

Do you take: ☐ Multi Vitamin ☐ Vitamin E ☐Aspirin ☐Motrin ☐Ibuprofen ☐Aleve ☐Tylenol ☐Coumadin ☐ Other Blood Thinner ☐ Supplements

SOCIAL HISTORY

▪Use of alcohol ☐ Never ☐ Social ☐ Daily

***If yes, in the last year how many days did you have 4 or more drinks per day** ______

▪Use of tobacco

☐ Never a Smoker ☐ Former Smoker
☐ Current EVERY DAY Smoker ☐ Current SOME DAY Smoker
☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Smokeless Tobacco

start date: ________ **end date:** ________

▪Use of tobacco Youth, Age 12-20 ☐ No ☐ Yes

RACE: Caucasian Latino Asian African American American Indian

ETHNICITY: Hispanic or Latino: **Yes or No**

LANGUAGE: English Spanish Other

Patient Signature______________________ **Date**______________

Relationship to Patient ☐ **Self** ☐ **Parent** ☐ **Guardian**

Welcome To Our Office

PLEASE PRINT and COMPLETE ALL PARTS

PATIENT NAME: (This section refers to PATIENT ONLY) **Today's Date** ______________

Name: ____ Date of Birth: __________

Nickname: ____

Address: ______________________ City: ______________ State: _____ Zip: __________

Sex: ____ Social Security # ________________ Email: ______________________________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ______________

EMPLOYER NAME: ____

Address: ____

Phone Number: ____

PRIMARY INSURED:

Name: ____

Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Significant Other ☐ Other

Address: ______________________ City: ______________ State: _____ Zip: __________

Phone #: ________________ Date of Birth: __________ Social Security # ______________

NOTIFY IN EMERGENCY: (ALTERNATE PHONE NUMBER)

Name: ________________________________

Relationship: ________________________________

Phone: ________________________________

SIGNATURE ____

Relationship to patient: ☐ self ☐ parent ☐ guardian

dr dermatology CENTER OF THE ROCKIES
MEDICAL | SURGERY | COSMETIC | SPA

Patient Name: ______________________ **Date of Birth:** ______________

What is your preferred method of contact for appointment reminders? PLEASE SELECT ONE.
☐ HOME ☐ WORK ☐ CELL / TEXT ☐ EMAIL

CONSENT FOR TEST RESULTS – I give Dermatology Center of the Rockies P.C. Permission to call the following numbers with: lab results, test results, other medical information and advice (**PLEASE SELECT ALL THAT APPLY**):

Please call my: ☐Home ☐ Cell ☐ Work
If unable to reach me: ☐You may leave a detailed message.
☐Please leave a message asking me to return your call.

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information to:
(**Please list name and contact information as desired**):

☐ **Name/Relationship:** ______________________

☐ **Information is not to be released to anyone.**

HIPAA Patient Consent Form

I hereby acknowledge that I have the right to receive a copy of this office's Notice of Privacy Practices, which explains how my protected health information may be used or disclosed. If you would like to receive a copy, please refer to our website or a staff member will be happy to give you one. I understand that I have the right to ask for a copy of this information. I authorize the release of any medical information and payment of medical benefits to be undersigned physician or supplier for services necessary to process a claim. I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: ______________________ Date__________

FINANCIAL AGREEMENT

I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance. If I **do not fulfill my financial agreement** with Dermatology Center of the Rockies, PC, I have been advised that **my account will be sent to collections within *30 days* of inactivity.** I have also been advised that I will be responsible for a **$30 charge if my account is sent to collections. Self-Pay and Cosmetic Patients must pay balance in full at time of service. This practice DOES NOT accept MEDICAID, CICP, or CHP+. By signing this agreement, I am also verifying that I do not have MEDICAID, CICP, OR CHP+ as a primary insurance. Dermatology Office Visit**

This Consent was signed by: ______________________ Date__________