Southern Marin Dermatology

Date: _____

WELCOME TO SMD!

Full Legal Name: _____

I prefer to be called: _____ Date of Birth: _____

Birth Sex: ☐ F ☐ M Height: _____ Weight: _____ Preferred Pronouns: She ☐He ☐Xe ☐They ☐ Other _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Mobile: _____ Work: _____

Please indicate a phone number you would prefer our staff to leave a confidential message for you: _____

Personal email: _____

☐ Mailing address if different from above: _____ State: _____ Zip: _____

Occupation or School: _____ Employer: _____

Work address: _____

Marital Status: ☐Married ☐Domestic Partner ☐Single ☐Widowed ☐Divorced ☐Separated ☐Engaged

Spouse/Partner Name: _____

Spouse's Employer: _____ Spouse's phone: _____

For children (under 18):

Parent/Guardian Name: _____ Relationship to patient: _____

Preferred phone number: _____ ☐ cell ☐ home ☐ other _____

Other Parent or Guardian: _____ Relationship to patient: _____

Preferred phone number: _____ ☐ cell ☐ home ☐ other _____

In case of emergency, SMD may contact:

☐ Spouse/partner listed above ☐ Parent/Guardian(s) listed above ☐ Other (list below):

Name: _____ Phone number: _____ Relationship to patient: _____

☐ I wish to have full cardiopulmonary resuscitation efforts (I am FULL CODE—I WANT ALL EFFORTS TO REVIVE ME)
☐ I have a DNR Order (DO NOT resuscitate)
☐ I have a DNI order (DO NOT intubate)

Insurance Information: ☐ I do NOT have medical insurance

Name of Insurance Company: _____

Preferred language: ☐ English ☐ Other: _____

Ethnicity: (optional) ☐ Hispanic ☐ Non-Hispanic

Race: (optional)

☐ Asian/South Asian ☐ African or African-American ☐ Caucasian/White ☐ Middle Eastern
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ _____

Southern Marin Dermatology

Name:_____ Date: _____

Have you ever seen Dr. Fardin, Dr. Smith, Dr. Westphal, Dr. Christman, Elisabeth Novak-Neal, PA, or Julia Parker, PA, in another office? ☐ Yes ☐ No **Where and when (approximately)?** _____

How did you hear about our office?

☐ I was referred by my Doctor/Health Care Practitioner: _____

☐ Online: ☐ Website ☐ Yelp ☐ Google ☐ SMMC ☐ Nextdoor ☐ Other: _____

Preferred pharmacy:

Name:_____

Location/Address: _____

Primary Care Physician (PCP): ☐ **I have no PCP currently**

Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Would you like your visit notes and results faxed to your PCP? ☐ Yes ☐ No

Medications:

Please list or attach a list of all your current **medications, doses and how often** you take each:
(Prescriptions, hormonal patches/implants/rings/shots, over-the-counter meds, vitamins and herbal supplements)

☐ **None**

Allergies:

Please list your medication/food allergies below and the reaction you get with each:

☐ **I have NO known drug allergies**

☐ Allergic to Latex
☐ Allergic to tape/adhesive
☐ Allergic to lidocaine /anesthetics
☐ Allergic to Neosporin/Bacitracin/Antibiotic ointment
☐ Fast heart rate with low doses of epinephrine

Medication/Food: Reaction:

_____

_____

_____

Vaccinations:

Have you received the 2022-23 influenza vaccine? ☐Yes ☐No

Sexual History:
___Not sexually active
___Sexually active with one partner
___Sexually active more than 1 partner
___Homosexual partner

Smoking:
___Every day cigarette smoker
___Every day other tobacco user
___Former smoker
___Rare smoker
___Never smoker

Alcohol Use:
___ **None**
___ **Less than 1 drink per day**
___ **1-2 drinks per day**
___ **3 or more drinks per day**

Southern Marin Dermatology

Name:_____ Date: _____

MEDICAL/SURGICAL HISTORY

What brings you to the office today?_____

Have you been treated for this before? ☐ Yes ☐ No

MEDICAL HISTORY

*Select any conditions you **currently** have:*

☐ **None**

___Anxiety
___Arthritis type: _____
___Asthma
___Atrial Fibrillation
___BPH/Enlarged Prostate
___Bone Marrow Transplantation
___Breast Cancer
___Colon Cancer
___COPD/Emphysema
___Coronary Artery Disease
___Depression
___Diabetes
___End Stage Renal Disease
___GERD/Acid Reflux
___Hearing Loss
___Hepatitis
___Hypertension
___HIV / AIDS
___Hypercholesterolemia
___Hyperthyroidism
___Hypothyroidism
___Leukemia
___Lung Cancer
___Lupus
___Lymphoma
___Pacemaker
___Prostate Cancer
___Radiation Treatment
___Seizures
___Stroke

Other: _____

WOMEN ONLY:
Are you pregnant? ☐ Yes ☐No
Trying to get pregnant? ☐ Yes ☐No
Nursing? ☐ Yes ☐No
If applicable, please list any contraception or hormones being used:_____

PAST SURGICAL HISTORY

Please indicate any surgeries & date(s):

☐ **No Surgeries**

☐ **I must take antibiotics before surgical procedures or dental cleaning**

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast : Mastectomy (Right, Left, Both)
Breast : Lumpectomy (Right, Left, Both)
Breast Biopsy (benign)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Surgery
Colectomy: Diverticulitis/Other
Colectomy: Inflammatory Bowel Disease
Gallbladder (Cholecystectomy)
Heart: Angioplasty (PTCA) or Stent
Heart: Coronary Artery Bypass Surgery
Heart: Defibrillator
Heart: Biological Valve Replacement
Heart: Mechanical Valve Replacement
Heart: Pacemaker
Heart: Transplant
Knee Surgery
Knee Replacement: (Right, Left, Both)
Kidney Biopsy
Kidney Removal (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovarian Removed: Cancer
Prostate (Prostatectomy) : Prostate Cancer
Prostate Biopsy
Spleen Removed (Splenectomy)
Testicle(s) removed (Orchiectomy)
Uterus surgery: Fibroids or Other
Uterus removed (Hysterectomy): Uterine Cancer
Uterus removed (Hysterectomy): Other reason

Other:_____

SKIN DISEASE HISTORY

___Acne
___Actinic Keratoses (precancers)
___Basal Cell Skin Cancer
___ Blistering Sunburns
___Dry Skin
___Eczema
___Flaking or Itchy Scalp
___Hay Fever / Allergies
___Melanoma
___MRSA infection
___Poison Oak/Ivy
___Precancerous or Dysplastic Moles
___Psoriasis
___Squamous Cell Skin Cancer
___Other Skin Biopsy
___ **NONE OF THE ABOVE**

Other:_____

Do you regularly:
Wear sunscreen? ☐ Yes ☐No SPF:___
Wear hats? ☐ Yes ☐No
Tan in a tanning salon? ☐ Yes ☐No

FAMILY HISTORY

Do you have a family history of Melanoma?
☐ Yes ☐ No ☐ Not Sure

Which relative? _____

Do you have a family history of:
Basal cell skin cancer (BCC)? ☐ Yes ☐No
Squamous cell skin cancer (SCC)? ☐ Yes ☐No
Pre-cancerous moles? ☐ Yes ☐No

Any other family history:_____

Southern Marin Dermatology

Name:_____Date: _____

REVIEW OF SYSTEMS: Indicate any that are ***recent or current*** symptoms:

SKIN/HAIR/NAIL
___*Problems with bleeding*
___*Problems with healing*
___*Problems with scarring (keloid/hypertrophic)*
___*Rash*
___*Itching*
___*Moles/Growths*
___*Acne*
___*Changes in nails*
___*Hair loss*
___*Other Concerns*

ALLERGIC/IMMUNOLOGIC
___*Immunosuppression*
___*Hay Fever*

CARDIAC
___*Chest pain*
___*Irregular Heartbeat*

GENERAL/CONSTITUTIONAL
___*Fever or Chills*
___*Night sweats*
___*Unintentional weight loss*

ENDOCRINE
___*Thyroid problems*

EAR/NOSE/THROAT
___*Sore throat*

EYE
___*Blurry vision*

DIGESTIVE
___*Abdominal pain*
___*Heartburn*

___*Blood in stools*

GENITOURINARY
___*Blood in urine*

MUSCULOSKELETAL
___*Joint pain or aches*
___*Muscle weakness*
___*Neck stiffness*

NEUROLOGICAL
___*Headaches*
___*Dizziness*
___*Seizures*

RESPIRATORY
___*Cough*
___*Shortness of breath*
___*Wheezing*

PSYCHIATRIC
___*Anxiety*
___*Depression*

HEMATOLOGIC / LYMPHATIC
___*Bleed or bruise easily*
___*Blood clots*
___*Swollen glands*
___*Swelling of extremities*

Are you regularly or sometimes taking any medicines or supplements that can thin the blood/cause bruising? ☐ Yes ☐ No
If Yes, Please circle:

Aspirin, Ibuprofen, Motrin, Naprosyn, Aleve, Coumadin, Plavix, Lovenox, Xarelto, Eliquis, Fish oils, Vitamin E, Omega 3 fatty acids, ginkgo biloba, garlic, licorice, CoQ10, cayenne, other:_____

Age 65 and Older ONLY:
Medicare Required Merit-based Incentive Payment System (MIPS) Questions:

Who is your health care proxy (someone who can make medical decisions for you in the event you are unable)?
Name: _____ Phone #: (____) _____ - _____
Have you had the PNEUMONIA vaccine? ☐ Yes ☐ No; If no, why not?

Southern Marin Dermatology

ACKNOWLEDGEMENT OF FINANCIAL AND OFFICE POLICIES

I, the undersigned, have read and understand the financial and office policies of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. **I understand that if I miss an appointment I will be charged $75 for medical appointments and a minimum of $150 for cosmetic and surgery appointments if 24 hours' notice of cancellation is not given.**

Patient's Name: _____
(please print)

Signature: _____ **Date**: _____

OR

Patient's Legal Representative's Name: _____
(please print)

Signature: _____ **Date:** _____

Describe Authority: _____

PATIENT CONSENT FOR ASSIGNMENT OF BENEFITS

SOUTHERN MARIN DERMATOLOGY will bill your insurance as a courtesy to you. If your insurance does not pay the claim within 60 days of the date of service, the balance of your account will be your responsibility. You are responsible for charges not covered by your insurance company. All copayments are due at the time of service. A fee of $ 25 will be charged for all checks returned from the bank.

Assignment of Benefits and Release of Information: I hereby authorize my insurance company to pay benefits directly to Southern Marin Dermatology. I authorize Southern Marin Dermatology, Inc. to release to my insurance company any information required to process insurance claims on my behalf.

Patient's Name: _____
(please print)

Signature: _____ **Date**: _____

OR

Patient's Legal Representative's Name: _____
(please print)

Signature: _____ **Date:** _____

Describe Authority: _____

Southern Marin Dermatology

HIPAA OMNIBUS RULE

NOTICE OF RECEIPT OF PRIVACY PRACTICES and PATIENT CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. Please note that, in refusing, we *may not be allowed* to process your insurance claims.

I, the undersigned, acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for Southern Marin Dermatology, Inc. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL SERVE AS A PHI (Personal Health Information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR LAB RESULTS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Patient's Name: _____ Date: _____
(PLEASE PRINT)

Signature: _____

For Minors under 18 or for those with Power of Attorney:

Guardian/Legal Representative's Name: _____
(PLEASE PRINT)

Description of Authority/Relationship to Patient: _____
(PLEASE PRINT)

Signature of Guardian/Legal Representative: _____ Date: _____

Your comments regarding Acknowledgements or Consents: _____

Your privacy is important to us. How do you prefer we address you when in the reception area?

○ First Name Only ○ MR / MRS / DR / MS / MISS _____ ○ Other _____

Please list any other persons who may have access to your health care information:
(This includes stepparents, grandparents and any caretakers who can have access to this patient's records)

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:
It was emergency treatment _____ I could not communicate with the patient _____ The patient refused to sign _____
The patient was unable to sign because
Other (please describe) _____

Signature of Privacy Officer: _____

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