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**Please complete all highlighted sections**

**PATIENT INFORMATION (Please Print)**

Date: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Sex: M / F Marital Status: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: Hispanic/Latino \_\_ Non-Hispanic/Non-Latino \_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Email for Patient Portal (1 patient per email): \_\_\_\_\_

Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Caretaker: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

**HEAD OF HOUSEHOLD (Responsible Financial Party)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION (Please present insurance card at time of check in)**

**Primary Insurance Name:** \_\_\_\_\_

Name of Member: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Relationship of patient to the Member \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

**Address if different from patient** \_\_\_\_\_

**Secondary Insurance Name:** \_\_\_\_\_

Name of Member: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Relationship of patient to the Member \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

**Address if different from patient** \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US? (Please circle all that apply)**

Friend/Family Insurance Instagram Facebook Online Reviews Google (search engine)

## Acknowledgement of Privacy Practices--HIPAA Agreement

By signing this form, I am confirming that I have been informed of my rights to privacy regarding my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Process insurance claims, insurance applications, and prescriptions.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I have been given the right to review and receive a copy of such Notice. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used to carry out TPO. I also understand that you are not required to agree to my requested restriction(s), but if you do agree then you are bound to abide by such restriction(s). If I do not sign this consent, Utah Valley Dermatology may decline providing treatment to me.

I have read and consent to the above information.

**Patient or Authorized Signature**

**(Relationship to Patient)**

**Date**

I authorize Utah Valley Dermatology to release my medical and/or billing information to the following individual(s):

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**May we leave a message on your primary phone?**

YES \_\_\_\_\_ NO \_\_\_\_\_

**May we email to the address listed, if any?**

YES \_\_\_\_\_ NO \_\_\_\_\_

**May we send you text messages?**

YES \_\_\_\_\_ NO \_\_\_\_\_

## Financial Responsibility (Office Policy on Payment)

By signing below, I agree to pay all amount(s) owed by me. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. I authorize insurance benefits to be paid directly to the provider. I may be billed separately for lab services. I am responsible for knowing the details of my insurance plan (specific doctors, pre-certifications, and/or referrals. Regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past due amounts at the rate of 18% per annum (1.5% per month) until paid in full.

In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 33.3% of the principal amount(s) owing as allowed by Utah Code. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) is/ are incurred today or after today. In the event of non-sufficient funds a \$25 fee will be assessed.

I am aware that my appointment is reserved for me and that missed appointments keep other patients from being seen. Patients must cancel an appointment 24 hours in advance or a cancellation fee may be assessed.

**Patient or Authorized Signature**

**(Relationship to Patient)**

**Date**

## MEDICAL HISTORY AND INTAKE FORM

Patient: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

### SOCIAL HISTORY:

- Smoking Status
- Current everyday smoker
- Current some day smoker
- Former smoker
- Never smoker

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Retired?      Yes      No

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### CURRENT OR PAST PROBLEMS WITH: (please check all that apply)

- Anxiety
- Arthritis
- Artificial joints
- Asthma
- Atrial fibrillation
- BPH (enlarged prostate)
- Crohn's Disease or Ulcerative Colitis
- Bone Marrow Transplantation
- Cancer (other than skin): \_\_\_\_\_
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- Reflux/GERD/Heartburn or Peptic Ulcers
- Hearing Loss

- Heart Attack
- Hepatitis (A, B, C)
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- Hyperthyroidism
- Hypothyroidism
- Immunosuppression Due to Medication
- Leukemia
- Lymphoma
- Pacemaker/Defibrillator
- Radiation Treatment
- Seizures
- Stroke
- None
- Other \_\_\_\_\_

### PAST SURGICAL HISTORY: (please check all that apply)

- Appendix Removed
- Bladder Surgery
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colectomy
- Gallbladder Removed
- Coronary Artery Bypass
- PTCA (procedure for blocked coronary arteries)
- Mechanical Valve Replacement
- Biological Valve Replacement
- Joint Replacement within last 2 years

- Kidney Removed (Right, Left)
- Transplant (Kidney, Liver, Heart, other)
- Ovaries Removed: (e.g. Endometriosis, Cyst, Ovarian Cancer)
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP (Prostate Procedure)
- Basal Cell Cancer Surgery
- Squamous Cell Carcinoma Surgery
- Melanoma Surgery
- Spleen Removed
- Hysterectomy
- None
- Other \_\_\_\_\_

### SKIN DISEASE HISTORY: (please check all that apply)

