UTAH VALLEY DERMATOLOGY

David Myers, MD ○ Jason Evans, PA-C ○ Scott Leatham, NP-C

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: _____

Primary Care Physician: _____

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)

TURN PAGE OVER -- Signature required

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:_____ DOB: _____

Primary Care Physician: _____

Reason for today's visit: _____ Date: _____

SOCIAL HISTORY:

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

Occupation: _____

Employer: _____

Retired? Yes No

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)

- ❑ Acne
- ❑ Actinic Keratosis (pre-cancers)
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ Fever Blisters/Cold Sores
- ❑ Other_____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Other family history of skin disease (e.g. Basal Cell or Squamous Cell Carcinoma, Psoriasis, Eczema)
_____

CURRENT MEDICATIONS (Prescription, Non-Prescription, Vitamins, Herbs)

_____
_____

VACCINATIONS: (Have you received any of the following) Pneumonia _____ Date _____ Flu_____ Date _____

ALLERGIES to medications and type of allergic reaction (example: hives, difficulty breathing, swelling, etc.)

_____
_____

PHARMACY OF CHOICE: _____
(Name) (City)

REVIEW OF SYSTEMS: Do you have a history of any of the following or are you experiencing any of the following items currently? (Please check all that apply)

- ❑ Changing mole(s)- experiencing currently
- ❑ Rash- experiencing currently
- ❑ Fever or Chills- experiencing currently
- ❑ New/concerning skin growth
- ❑ Problems with healing
- ❑ Problems with scarring (hypertrophic or keloid
- ❑ Yeast infections with antibiotics
- ❑ GI/stomach problems with antibiotics
- ❑ History of fainting
- ❑ Problems with bleeding
- ❑ History of Accutane
- ❑ Allergy to adhesive (tape bandages)
- ❑ Allergy to topical antibiotic ointments
- ❑ History of melanoma
- ❑ History of basal cell or squamous cell cancer
- ❑ Immunosuppression
- ❑ Organ transplant
- ❑ Allergy to lidocaine
- ❑ Rapid heartbeat with epinephrine
- ❑ Currently pregnant or planning pregnancy
- ❑ Blood thinners
- ❑ Do you have a pacemaker or defibrillator

Comments or other concerns: _____
_____
_____