ORANGE DERMATOLOGY ASSOCIATES, P.C.

(Side 1)

MEDICAL HISTORY

NAME:____ DOB:____________ Today's Date:___/___/___

CURRENT PROBLEM (HPI):

1. Reason for visit **(circle)** (rash, growths, skin cancer check, other)_______________________________________

2. How long have you had this problem?________________________

	YES	NO
3. Where is your problem located? **(circle)** Scalp, ears, eyelids, face, neck, chest, back, arms, underarms, hands, fingers, stomach, groin, thighs, legs, feet, toes, hair, nails, mouth	☐	☐
4. Does the problem **(circle)** itch, burn, hurt, bleed, ooze, other?_________________________	☐	☐
5. Has a doctor given you anything in the past to put on or take by mouth for your present skin problem? If yes, please list: ____	☐	☐
6. Have you put anything else on the skin yourself? If yes, please list: ____	☐	☐

MEDICATIONS: (Oral or Topical)

a) Are you currently taking **ANY** medications by **MOUTH** (including prescriptions, hormones, birth control pills, over-the-counter supplements, vitamins and herbals) or suppositories, eye drops, ear drops; or putting anything on your skin? ☐ ☐

b) If yes, please list: ____

____

____

ALLERGIES: (Oral or Topical medications) **Please specify (e.g. rash, hives, itching, etc.)** ☐ ☐

Medication:________________________________ Reaction: ______________________________

Medication:________________________________ Reaction:______________________________

Medication:________________________________ Reaction:______________________________

SOCIAL HISTORY:

	YES	NO	UNKNOWN
Have you ever smoked?	☐	☐	☐
Do you smoke every day?	☐	☐	☐
Do you smoke sometimes?	☐	☐	☐
Do you still smoke?	☐	☐	☐
Do you drink alcohol regularly?	☐	☐	
Have you had or been exposed to HIV (AIDS)?	☐	☐	

What is your Occupation?

____

Hobbies?

____

____

YOUR PERSONAL
PAST OR PRESENT SKIN CONDITIONS:

	YES	NO
Skin cancer Type______________________	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Other skin condition Please list**:** ____________________________________	☐	☐
Asthma	☐	☐
Hay Fever	☐	☐
Problems healing	☐	☐
Thick or elevated scars after surgery	☐	☐
Bleed easily	☐	☐

FAMILY HISTORY: Indicate relationship
(If grandmother or grandfather, **INDICATE** which one, and **ALSO** add **(m)** for maternal or **(p)** for paternal)

	YES	NO	
Skin cancer	☐	☐	______________________________
Psoriasis	☐	☐	______________________________
Eczema	☐	☐	______________________________
Asthma	☐	☐	______________________________
Hay Fever	☐	☐	______________________________

Any other family skin condition? Please list:

____

____

(PLEASE COMPLETE BOTH SIDES)

(Side 2)

YOUR PERSONAL
PAST OR PRESENT MEDICAL HISTORY

	YES	NO
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis (Vein inflammation)	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐
Angina	☐	☐
Heart Surgery	☐	☐
Diabetes	☐	☐
Strokes	☐	☐
Depression	☐	☐
Thyroid Disease	☐	☐
Kidney Disease/Dialysis **(circle)**	☐	☐

	YES	NO
Colitis/Inflammatory Bowel Disease	☐	☐
Heartburn/Acid reflux/Ulcers **(circle)**	☐	☐
Hepatitis, If yes, what type?_______	☐	☐
Arthritis/Joint/Muscle Disease **(circle)**	☐	☐
Osteopenia/Osteoporosis **(circle)**	☐	☐
Artificial joints	☐	☐
Convulsions/Epilepsy/Seizures **(circle)**	☐	☐
Multiple Sclerosis or other Neurologic disorders **(circle)** _________________	☐	☐
Immune Problems________________ ______________________________	☐	☐
Cancer, Type? _________________	☐	☐

Other diseases or conditions not listed above: ___________
____
____

List surgical procedures you have had in the last 6 months:_______________________________________
____

Name/Address/Telephone No. of your **Primary Care Physician** : ____________________________________
____

Were you referred by **(circle)** physician, friend, relative, other? **YES** ☐ **NO** ☐
Name:____

FEMALES ONLY

	YES	NO
Are you pregnant?	☐	☐
Are you breastfeeding?	☐	☐

COSMETIC PROCEDURES:

Are you interested in getting or receiving more information and/or promotions? ☐ **Yes** ☐ **No**

- LASER hair removal
- LASER removal of facial redness and spider veins
- LASER removal of brown or dark spots
- "Filler" (Juvederm, Restylane, Radiesse, etc.) injections
- BOTOX Cosmetic

Completed by: ☐ Patient
☐ Medical Assistant _______

___________________________________ Date ___/___/___
Signed by Patient/Parent/Guardian

___________________________________ Date ___/___/___
Reviewed by

(HAVE YOU COMPLETED BOTH SIDES?)

ORANGE DERMATOLOGY ASSOCIATES, P.C.

PATIENT INFORMATION (*Please Print*)

Name____SS#_____________________
Last *First* *M.I.*

Date of Birth ___/___/___ Age_____ Gender_____ Marital Status______ Occupation______________

Mailing Address____
City *State* *Zip*

Home # ___________________ Cell #_______________________ Work # ________________________

Emergency Contact Name/Relationship: ______________________________ Phone #________________

For Patient Portal Access: Email Address ____
(Are you interested in receiving more information via email about cosmetic procedures and/or promotions? Yes ☐ No ☐)

Federal Government Requirement Race____________ Ethnicity____________________ Decline ☐

POLICY HOLDER /RESPONSIBLE PARTY ***(if different from patient)***

Name____SS#_____________________
Last *First* *M.I.*

Date of Birth___/___/___ Gender_______ Marital Status_________ Occupation_________________

Mailing Address____
City *State* *Zip*

Home #______________________Cell # _________________________ Work #_____________________

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

Primary Insurance Name______________________
Name of Insured______________________________
Insured's ID#___________________________
Employer Name_______________________________
Relationship to patient _______________________

Secondary Insurance Name______________________
Name of Insured______________________________
Insured's ID#__________________________________
Employer Name_______________________________
Relationship to patient _______________________

PHARMACY NAME, ADDRESS & PHONE# ____
____

PRESCRIPTION PLAN ID NO.____

(PLEASE COMPLETE BOTH SIDES)

<u>WE RESPECT YOUR PRIVACY</u> (Our HIPAA Policy is posted in the office)

I authorize the release, as necessary, of my medical information, or that of my dependents, to my primary care or referring physicians, or to consultants, or to process insurance claims and prescriptions. I also authorize payment of my medical benefits, whether private or governmental (Medicare), to Orange Dermatology Associates, P.C. for all professional services rendered by their providers to me or my dependents.

I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered, including any unmet deductibles, co-payments and non-covered services. If my account is turned over to a collection agency or if I fail to keep a scheduled appointment, a service charge will be added.

To insure patient confidentiality, our office policy is to give test results to the patient only. If we call your home and another member of your household answers the telephone, may we leave results? Yes ☐ No ☐
May we leave personal medical information on your answering machine at home? Yes ☐ No ☐
May we leave personal medical information on your cell phone? Yes ☐ No ☐
May we call your cell phone to confirm your appointment? Yes ☐ No ☐

I acknowledge reading this entire page including the posted HIPAA privacy notice.

Patient or Responsible Party (if minor)

Signature____Date___/___/___

Print Name ____

ORANGE DERMATOLOGY ASSOCIATES, P.C.
www.orangederm.com

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INFORMED CONSENT FOR PROCEDURES

My signature on this form authorizes the Doctors and Physician Assistants of Orange Dermatology Associates, P.C. to perform procedures on me that they feel are necessary for my well being, including, but not limited to injections, freezing with liquid nitrogen (cryosurgery), electrodesiccation, biopsy and excisions. Before any procedure is done, I will be informed, to my satisfaction why the procedure is necessary. I will be told what the procedure involves and what risk there is to my health, if any, if the condition were to remain undiagnosed or untreated.

I understand the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, the formation of thick or otherwise objection-able scars, skin color changes, and possible recurrence and I realize that such, or any, natural complications may result from the surgical procedure.

I give my permission to have any tissue(s) removed during the procedure be sent for histologic examination by a pathologist.

____

Signature of patient or patient's legal guardian Date
Signifying informed consent

____

Witness Date

DATE	PROCEDURE	SIGNATURE

Orange Dermatology Associates, P.C.

In an effort to provide our patients with a comfortable and professional experience in our office, Orange Dermatology Associates, P.C. is pleased to offer the option of a chaperone to be with you during your skin examination.

Please indicate below if you would like a chaperone to be with you in the room during the examination along with the doctor and/or physician assistant.

Your preference will remain in effect until you notify us otherwise.

_____ Yes, I would like a chaperone.

_____ No, I do not want a chaperone.

____ ____________

Signature Date

____

Print name