

# History and Intake Form

**Legal Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Sex Assigned at Birth:** Male: \_\_\_\_ Female: \_\_\_\_ **Gender:** Male: \_\_\_\_ Female: \_\_\_\_ Other: \_\_\_\_  
**Preferred Pronouns:** She/her/hers \_\_\_\_\_ He/him/his \_\_\_\_\_ They/them/theirs \_\_\_\_\_  
**Race/Ethnicity:** \_\_\_\_\_  
**Pharmacy (name/address/phone #):** \_\_\_\_\_

**Reason for today's visit:**

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** (please circle all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease

- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Head Trauma
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia

- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

**Other:**

**Past Surgical History:** (please circle all that apply)

- Appendix Removed
- Bladder Removed
- Breast Biopsy (right, left, bilateral)
- Lumpectomy (right, left, bilateral)
- Mastectomy (right, left, bilateral)
- Colectomy
- Colostomy
- Gallbladder Removed
- Coronary Artery Bypass
- Angioplasty (PTCA)
- Biological Valve Replacement
- Mechanical Valve Replacement
- Heart Transplant
- Hip Replacement (right, left, bilateral)
- Knee Replacement (right, left, bilateral)
- Kidney Biopsy

- Kidney Removed (right, left)
- Kidney Stone Removal
- Kidney Transplant
- Hepatectomy
- Liver Transplant
- Liver Shunt
- Ovaries Removed (endometriosis, cancer, cyst)
- Tubal Ligation
- Pancreas Removed
- Prostate Removed (cancer, TURP)
- Rectal Resection
- Spleen Removed
- Testicles Removed (right, left, bilateral)
- Hysterectomy (fibroids, uterine cancer, cervical cancer)

**Other:**

**Skin Disease History:** (please circle all that apply)

- Acne
- Actinic Keratosis
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns

- Dry Skin
- Eczema
- Flaking/Itchy Scalp
- Hay Fever/Allergies
- Melanoma

- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

**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 MALIGNANT MELANOMA?**

YES       NO

*If yes, which relative (s):* \_\_\_\_\_

**MEDICATIONS** (please list all current medications):


NO MEDICATIONS

**DRUG ALLERGIES** (please list all known allergies and reactions):


NO KNOWN DRUG ALLERGIES

**SOCIAL HISTORY:**

**Smoking Status:**       Current every day smoker       Current someday smoker  
 Former smoker       Never smoker

**Alcohol Use:**       None       < 1 drink per day       3 or more drinks per day

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

**ALERTS:** (please circle all that apply)

<ul style="list-style-type: none"> <li>• Allergy to adhesive</li> <li>• Allergy to latex</li> <li>• Allergy to lidocaine</li> <li>• Artificial valve replacement</li> </ul>	<ul style="list-style-type: none"> <li>• Artificial joint replacement</li> <li>• Blood thinners</li> <li>• Defibrillator</li> <li>• Keloid scarring</li> </ul>	<ul style="list-style-type: none"> <li>• MRSA</li> <li>• Pacemaker</li> <li>• Require antibiotics prior to procedure</li> <li>• Rapid heart beat with epinephrine</li> </ul>
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**ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT?**       YES       NO

**REVIEW OF SYSTEMS:** Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
<b>Are you in generally good health?</b>		
<b>Do you have problems with bleeding?</b>		
<b>Do you have problems with healing?</b>		
<b>Do you have problems with scarring?</b>		
<b>Do you currently have a rash?</b>		
<b>Do you have any new skin lesions?</b>		
<b>Do you have any changing skin lesions?</b>		

Completed by:  Patient  
 Medical Assistant \_\_\_\_\_  
Initials

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signed by Patient      Date  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Reviewed by      Date

**PLYMOUTH DERMATOLOGY ASSOCIATES, P.C.**  
*PATIENT INFORMATION SHEET*

**NAME:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_\_  
FIRST M. I. LAST

**CIRCLE ONE:**    Single                      Married                      Widowed                      Divorced

**MAILING Address:** \_\_\_\_\_  
STREET # OR PO BOX                      TOWN                      STATE, ZIP CODE

**HOME PHONE:** \_\_\_\_\_ **CELL Phone:** \_\_\_\_\_

**PATIENT E-MAIL:** \_\_\_\_\_

**PRIMARY CARE DOCTOR:** \_\_\_\_\_ **TELEPHONE** \_\_\_\_\_

**INSURANCE NAME:** \_\_\_\_\_ **SUBSCRIBER NO.** \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY FOR INSURANCE:** \_\_\_\_\_

**RESPONSIBLE PARTY FOR A MINOR CHILD:** \_\_\_\_\_

**ADDRESS IF DIFFERENT FROM PATIENT:** \_\_\_\_\_

**TELEPHONE IF DIFFERENT FROM PATIENT:** \_\_\_\_\_

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS. I AUTHORIZE PAYMENTS OF MEDICAL BENEFITS TO PLYMOUTH DERMATOLOGY ASSOCIATES, P.C. FOR SERVICES PROVIDED. I AUTHORIZE TREATMENT OF MY SON/DAUGHTER. This information is accurate and true to the best of my knowledge. I understand I am responsible to pay for services rendered, including fees and cost of collections in the event of default.

**SIGN NAME OF PATIENT/PARENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**COSMETIC INTEREST QUESTIONNAIRE**

PLEASE CIRCLE ANY OF THE FOLLOWING ISSUES YOU WOULD LIKE TO RECEIVE MORE INFORMATION ON.

Fine Lines and Wrinkles  
Eyelashes: Wish to be Longer, Fuller, Darker  
Overall Skin Rejuvenation / Skin Care Advise  
Age Spots/ Facial Pigmentation Problems

Facial Fillers  
Medical Skin Care Products/Retinol  
Laser Hair Removal  
Botox

# Receipt of Notice of Privacy Practices Written Acknowledgement Form

*Plymouth Dermatology*  
ASSOCIATES PC

I am a patient of Plymouth Dermatology Associates, PC. I hereby acknowledge receipt of Plymouth Dermatology Associated PC's Notice of Privacy Practices.

Name [please print]: \_\_\_\_\_

Signature: \_\_\_\_\_

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

**OR**

I am a parent or legal guardian of \_\_\_\_\_ (patient name). I hereby acknowledge receipt of Plymouth Dermatology Associated PC's Notice of Privacy Practices with respect to the patient.

Name (please print): \_\_\_\_\_

Relationship to Patient:       Parent       Legal Guardian

Signature: \_\_\_\_\_

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

# NOTICE OF PRIVACY PRACTICES

## *Plymouth Dermatology* ASSOCIATES PC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical record only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fund raising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fund raising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operation;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of **September 18, 2013** and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Anne-Sophie Gadenne, MD, 508-746-5300 for more information, in person or in writing.