DLA DERMATOLOGY & LASER OF ALABAMA

****Please be sure to fill out EVERY section thoroughly. Indicate N/A for sections that do not apply to you**

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Marital Status: _____ Occupation/Employer: _____

Home Number: (_____)_____ Cell Number: (_____)_____

Preferred Contact Method (circle one): Home or Cell Is it ok to leave a detailed voicemail? Yes or No

Social Security Number: _____-_____-_____ Email Address: _____

Preferred Language: _____ Race and Ethnic Group: _____

Emergency Contact: _____ Number for Emergency Contact (_____)_____

Reason for visit today: _____

How did you hear about us? _____

Insurance:

Primary
Contract ID #: _____ Group #: _____ Policy Holder/DOB: _____
Secondary
Contract ID #: _____ Group #: _____ Policy Holder/DOB: _____

Preferred Pharmacy:

Name: _____ Phone Number: (_____)_____ City or Zip Code: _____

Primary Care Physician (PCP):

Doctor's Name: _____ ☐ No current primary care physician

Name of Referring Physician if applicable and different from PCP: _____

Past Medical History: (please circle all that apply) ☐ None of these apply

Anxiety	Hepatitis
Arthritis	Hypertension (high blood pressure)
Artificial Joints	HIV / AIDS
Asthma	Hypercholesterolemia (high cholesterol)
Atrial Fibrillation	Hyperthyroidism
BPH (Benign Prostatic Hyperplasia)	Hypothyroidism
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer

Colon Cancer	Lymphoma
COPD (Emphysema)	Migraines
Coronary Artery Disease	Pacemaker
Depression	Prostate Cancer
Diabetes	Radiation Treatment
End Stage Renal Disease	Seizures
GERD (Acid Reflux)	Stroke
Hearing Loss	Valve Replacement

Any other medical condition not listed above:

_____

Past Surgical History: (please circle all that apply) ☐ None of these apply

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removed
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Lung Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Augmentation	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP
Coronary Artery Bypass	Skin Biopsy
Coronary Stent	Basal Cell Carcinoma Surgery
Mechanical Valve Replacement	Squamous Cell Carcinoma Surgery
Biological Valve Replacement	Melanoma Surgery
Heart Transplant	Spleen Removed
Joint Replacement, Knee	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Hip	Hysterectomy: Fibroids
Joint Replacement (within last 2 years)	Hysterectomy: Uterine Cancer

Any other surgical procedure not listed on previous page: _____

Skin Disease History: (please circle all that apply) ☐ None of these apply

Acne	Eczema
Actinic Keratosis (precancerous lesions)	Flaking or Itchy Scalp
Basal Cell Skin Cancer	Melanoma
Blistering Sunburns	Psoriasis
Dysplastic Nevi (precancerous moles)	Seasonal Allergies / Hayfever
Dry Skin	Squamous Cell Skin Cancer

Any other skin condition not listed above:

_____

Sun Protection:

Do you wear sunscreen? Yes No

If yes, what SPF? _____

Have you ever used a tanning bed? Yes No

If yes, do you use a tanning bed currently? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

Allergies: Please list all medication allergies & your reaction to the medication

☐ No Known Drug Allergies

_____

_____

Medications: Please list all medications, dose & frequency, including vitamins & supplements.

☐ No current medications

_____

_____

_____

_____

_____

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_____

Social History: Please ensure you complete this section entirely.

Alcohol Intake: (please circle one)	**Smoking Status:** (please circle one)
None	Current everyday smoker
Less than 1 per day	Current someday smoker
2-3 per day	Former smoker
3 or more per day	Never smoker

If you are age 65 or older, have you ever received the pneumonia vaccination? Yes OR No

Alerts: Please check all the apply

- ☐ Current use of a blood thinner
- ☐ History of blood clots
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Artificial Joint
- ☐ HIV / AIDS
- ☐ Pregnant
- ☐ Breast feeding
- ☐ Planning pregnancy
- ☐ Allergy to lidocaine
- ☐ Sensitivity to epinephrine
- ☐ Transplant
- ☐ History of melanoma
- ☐ Immunosuppression
- ☐ Hepatitis
- ☐ History of MRSA
- ☐ Increased risk of thrombosis

FOR WOMEN ONLY:

Are you having a menstrual cycle?	Yes or No
If yes, when was your last menstrual cycle?	
Have you had a hysterectomy?	Yes or No

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_____ I consent to necessary treatment of diagnostic tests/procedures including drug, medicines, performance of operations and conduct of studies that may be conducted by Dr. Sawyer, Dr. Smith and/or their staff.

_____ I understand that I may be charged a $50 fee for a missed appointment.

_____ I understand that if I am uninsured or have an insurance that is not accepted at the practice, that I will be responsible for payment IN FULL at the time of service.

_____ I understand insurance copays and charges not filed with insurance are due at the time of service. Failure to make payments when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State of Alabama and any other state.

_____ I understand that I will be responsible for ANY charges that are not paid by my insurance company. Not all services are covered and I understand that is MY RESPONSIBILITY to know the limits of my coverage and to pay any fees that my insurance company denies. (As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask that you pay in full at your visits and file your own claims.)

_____ I understand that most procedures fall under major medical, therefore I will be responsible for paying the deductible amount at the time of service. Procedures include treatment of skin lesions (including warts, molluscum, moles, skin tags, precancers, skin cancer) by ANY method (including freezing, biopsy, and in-office application of medication.)

_____ I authorize the release of medical information to my primary care or referring physician, to consultations if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

_____ I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or any related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for the treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.)

_____ I am aware that the practice has a Notice of Privacy Policies that contains a section on Patient Rights. I have been given the opportunity to review this notice and the option to obtain a personal copy.

_____ By initialing here, you give DLA consent to send automated text messages and/or emails that will include information about promotions, events, and other marketing information.

Patient or Responsible Party (signature): _____ Date: ____/____/____

HIPPA authorization form

Personal Representatives

To ensure the quality of the services / treatment we provide to you, please be advised that post-operative care information may be disclosed to the individual that accompanies you on the date of service.

____ DLA may NOT disclose my medical information (i.e. medical financial) information to anyone.

____ I give DLA permission to disclose my medical information (i.e. medical and financial) information.

Please list the FULL NAME of the individual to whom we may disclose your information.

____ my spouse: _____

____ parents: _____

____ adult children: _____

____ friends: _____

(If you're a minor, i.e. under the age of 18, and your parent / guardian is the guarantor of your services, we may disclose your medical and financial information to them for collection of fees you may owe.)

The sole purpose of this consent is to maintain maximum protection of you Public Health Information (PHI) at all times.

_____

(Patient / Guardian Signature)

_____

(Witness Signature)