# Anders Dermatology Inc.

**Patient Name**_____**Date of Birth**_____

**Email address**_____

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

| | | |
|---|---|---|
| Anxiety | Diabetes | Lung Cancer |
| Arthritis | End Stage Renal Disease | Lymphoma |
| Asthma | GERD | Mitral Valve |
| Atrial fibrillation | Hearing Loss | Prostate Cancer |
| Bone Marrow Transplantation | Heart Failure | Radiation Treatment |
| BPH | Hepatitis | Seizures |
| Breast Cancer | High Blood pressure | Stroke |
| Colon Cancer | HIV/AIDS | TB |
| COPD | High Cholesterol | NONE |
| Coronary Artery Disease | Thyroid Problems (Hyper or Hypo) | |
| Depression | Leukemia | |

Other _____

**Past Surgical History**: (please list all)

_____

_____

_____

_____

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

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratoses | Eczema | Precancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever/Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | |
| | | NONE |

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

**Family History** (List relationship)- Melanoma_____ Skin Cancer_____

Rosacea _____Psoriasis _____ Eczema _____ Diabetes _____

Allergies _____ Heart DZ _____ High B/P _____ Stroke _____ TB_____

**(PLEASE SEE OTHER SIDE)**

**Medications**: (Please enter all current medications)

_____
_____
_____
_____

**Allergies**: (Please enter all allergies)

_____
_____
_____

**Social History**: (Please circle all that apply)

**Cigarette Smoking/Tobacco Use:**
Never
Quit: Former Smoker/User
Smokes/Uses Tobacco Less Than Daily
Smokes/Uses Tobacco Daily

**Alcohol:**
None
Less than 1 drink a day
1-2 drinks per day
3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? (please circle)

0 1 2 3 4 5

How often do you exercise_____

What is your caffeine use? _____

Have you received a pneumonia vaccination? Y N Have you received a flu vaccination? Y N

Do you have a living will? Y N Proxy /Designee's name _____ Phone number_____

Do you have a Pacemaker Y N , Defibrillator Y N , Artificial Joint Y N , Year _____, Where_____

**Pharmacy Name:**_____

Street:_____ Zip code:_____

**Primary Care Provider:**_____

Date of last visit with Primary Care Provider: _____

**Referring Physician:**_____

Fax Number:_____

(Please Print) **ANDERS DERMATOLOGY, INC.** (Please Print)

PATIENT NAME: _____
(LAST) (FIRST) (M.I)

ADDRESS: _____
(STREET) (APARTMENT #) (CITY) (STATE) ( ZIP CODE)

STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED PHONE: ( ____ ) _____

BIRTHDATE: _____ AGE: _____ SEX: _____ *OK to Leave a Message?* ☐ *YES* ☐ *NO*

SOCIAL SECURITY #: _____ CELL PHONE: ( ____ ) _____

E-MAIL: _____ RACE: _____ ETHNICITY: _____

EMPLOYER: _____ OCCUPATION: _____

PHONE: ( ____ ) _____ ADDRESS: _____

## PARENT / GUARDIAN / RESPONSIBLE PARTY

NAME: _____
(LAST) (FIRST) (M.I) (RELATIONSHIP TO PATIENT)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

SOCIAL SECURITY #: _____ HOME PHONE: _____

WORK PHONE: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

## INSURANCE

**(IN ORDER FOR US TO FILE YOUR INSURANCE, PLEASE BE SURE TO COMPLETE THE FOLLOWING AND PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST.)**

PRIMARY INSURANCE TO FILE: _____

NAME OF INSURANCE POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER ADDRESS: _____ PHONE: _____

POLICY # _____ GROUP # _____ S. S. # _____

DATE OF BIRTH: _____ EMPLOYER: _____ PHONE: _____

SECONDARY INSURANCE TO FILE: _____

NAME OF INSURANCE POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER ADDRESS: _____ PHONE: _____

POLICY # _____ GROUP # _____ S. S. # _____

DATE OF BIRTH: _____ EMPLOYER: _____ PHONE: _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf, or to myself.
**I understand that I am financially responsible for all charges not covered by my insurance.**

SIGNATURE: _____ **DATE:** _____

**(OVER)**

Anders Dermatology, Incorporated
4126 N. Holland Sylvania Rd., Suite 200
Toledo OH 43623

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name_____ Date of Birth _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below from Anders Dermatology, Incorporated:

Results from any laboratory testing (skin and/or blood), medications prescribed, diagnosis of my skin disease and/or treatment thereof, insurance response/payment, account balance due, appointment scheduled with us or with another Medical Provider.

Person(s) receiving my authorized information include:

Name_____ Their relationship to me_____ Phone _____

Name_____ Their relationship to me_____ Phone _____

Name_____ Their relationship to me_____ Phone _____

I understand that I have the right to cancel this authorization at any time by notifying Anders Dermatology, Incorporated in writing. If I choose to do so, my cancellation will not affect any actions taken by Anders Dermatology Incorporated before receiving my cancellation notification. I understand that the cancellation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**This authorization will expire one year from date signed.**

**Patient Signature** _____
**Or Legal Representative / relationship to patient**

**Date Signed** _____

## ANDERS DERMATOLOGY, INC.

## PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that**:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice Of Privacy Practices
- The Patient reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease

**This Consent was signed by**:_____

Printed Name-Patient or Representative/ Relationship

_____ ___/___/___

Signature Date