Patient Name:_____D.O.B_____

Please check all the following boxes that apply:

Past Medical History

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation (Irregular heartbeat)
- ❑ BPH (Enlarged prostate)
- ❑ Bone Marrow Transplant
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD (Gastric Reflux)
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ Hypercholesterolemia (High Cholesterol)
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Other _____
- ❑ NO PAST MEDICAL HISTORY

Past Surgeries

- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast: Mastectomy (Right Breast)
- ❑ Breast: Mastectomy (Left Breast)
- ❑ Breast: Mastectomy (Both Breasts)
- ❑ Breast: Lumpectomy (Right Breast)
- ❑ Breast: Lumpectomy (Left Breast)
- ❑ Breast: Lumpectomy (Both Breasts)
- ❑ Breast: Breast Biopsy
- ❑ Breast: Breast Reduction
- ❑ Breast: Breast Implants
- ❑ Colon (Colectomy): Colon Cancer Resection
- ❑ Colon (Colectomy): Diverticulitis
- ❑ Colon (Colectomy): Inflammatory Bowel Dz
- ❑ Gallbladder (Cholecystectomy
- ❑ Heart: Coronary Artery Bypass Surgery
- ❑ Heart: PTCA (Angioplasty)
- ❑ Heart: Mechanical Valve Replacement
- ❑ Heart: Biological Valve Replacement
- ❑ Heart: Heart Transplant
- ❑ Joint Replacement: Knee (Right)
- ❑ Joint Replacement: Knee (Left)
- ❑ Joint Replacement: Knee (Both)
- ❑ Joint Replacement: Hip (Right)
- ❑ Joint Replacement: Hip (Left)
- ❑ Joint Replacement: Hip (Both)
- ❑ Kidney:Kidney Biopsy
- ❑ Kidney:Nephrectomy (Kidney removal)
- ❑ Kidney: Kidney Stone Removal
- ❑ Kidney: Kidney Transplant

Past Surgeries continued……..

- ❑ Ovaries (Oophorectomy): Endometriosis
- ❑ Ovaries (Oophorectomy): Ovarian Cyst
- ❑ Ovaries (Oophorectomy): Ovarian Cancer
- ❑ Prostate (Prostatectomy): Prostate Cancer
- ❑ Prostate (Prostatectomy): Prostate Biopsy
- ❑ Prostate (Prostatectomy):TURP
- ❑ Skin: Skin Biopsy
- ❑ Skin: Basal Cell Carcinoma Surgery
- ❑ Skin: Squamous Cell Carcinoma Surgery
- ❑ Skin: Melanoma Surgery
- ❑ Spleen (Splenectomy): Spleen Removal
- ❑ Testicles (Orchidectomy): Testicle Removal
- ❑ Uterus (Hysterectomy): Fibroids
- ❑ Uterus (Hysterectomy): Uterine Cancer
- ❑ Other:_____
- ❑ NO PAST SURGICAL PROCEDURE

Skin Disease History

- ❑ Acne
- ❑ Actinic Keratoses (Precancers)
- ❑ Asthma
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/ Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous/ Dysplastic Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ NO PAST SKIN PROBLEMS

Skin History

Do you wear sunscreen?

- ❑ YES. What SPF do you apply?____
- ❑ NO.

Do you tan in a tanning salon?

- ❑ YES.
- ❑ NO.

Pneumonia Vaccine

Did you receive the Pneumonia Vaccine?

- ❑ YES.
- ❑ NO.
- ❑ UNKNOWN.

Drinking Alcohol History

- ❑ No Alcohol
- ❑ Less than 1 drink per day
- ❑ 1-2 Drinking per day
- ❑ 3 or more drinks per day

Smoking History

- ❑ Current everyday smoker
- ❑ Current some day smoker(Cigarette)
- ❑ Current some smoker (Other Tobacco)
- ❑ Former Smoker
  Quit smoking date____/____/____
  Total Years smoking_____
- ❑ Never Smoker

Review of Systems: Have recently experienced any of the following:

- ❑ Changing, Bleeding, or Itching mole/Lesion
- ❑ Rash
- ❑ Itching
- ❑ Burning Skin
- ❑ Fever/ Chills
- ❑ Unintentional Weight loss
- ❑ Night Sweats
- ❑ Muscle Weakness
- ❑ Joint Aches
- ❑ Neck Stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ Blurry Vision
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Sore Throat
- ❑ Abdominal Pain/Nausea/Vomiting
- ❑ Bloody Stool
- ❑ Depression
- ❑ Hay Fever
- ❑ Problems Healing
- ❑ Burning with Urination
- ❑ Heat r cold intolerance
- ❑ Frequent nose bleeds
- ❑ NONE

Alerts Important info to know about you:

- ❑ Defibrillator
- ❑ Pacemaker
- ❑ Artificial Joint Placed in Last 2 Years
- ❑ Artificial Heart Valve
- ❑ Antibiotic Prophylaxis
- ❑ History of scarring (Keloid)
- ❑ History of Passing Out (Vasovagal)
- ❑ Organ Transplant Recipient
- ❑ Immunosuppressed (Low immunity)
- ❑ Allergy to Adhesive
- ❑ Pregnant or planning a pregnancy
- ❑ Breast Feeding
- ❑ Stomach upset with antibiotics
- ❑ Yeast infection with antibiotics
- ❑ Allergy to Topical antibiotics
- ❑ Anti-coagulated (on blood thinners)
- ❑ Allergic to lidocaine
- ❑ Rapid Heartbeat with Epinephrine
- ❑ HIV/AIDS
- ❑ Hepatitis V
- ❑ History of MRSA
- ❑ Problem with UV therapy
- ❑ Heart Stent
- ❑ Problem with Steroids
- ❑ History of Heart attack
- ❑ History of atrial fibrillation
- ❑ Arrhythmia
- ❑ Latex Allergy
- ❑ West Africa:Travel or Contact
- ❑ NONE

Primary Care Physician

Name: _____
Referred you to our practice? YES / NO
Phone:_____
City: _____
Hospital Affiliation:_____
Send Results to PCP? YES / NO

Prefered Pharmacy Information

Pharmacy Name:_____
Phone Number:_____
Zip Code: _____

How did you hear about us?

- ❑ Physician:_____
- ❑ Family: _____
- ❑ Friend:_____
- ❑ Insurance Referral
- ❑ Internet Search
- ❑ Other:_____

Family History of Melanoma

Do you have a family history of Melanoma

- ❑ YES. Which Relative(s)?_____
- ❑ NO

Family History of other Cancer

- ❑ YES
  Relative_____Type: _____
  Relative_____Type: _____
- ❑ NO

Female Patients only

Are you Pregnant?

- ❑ YES Due Date____/____/____
- ❑ NO

Are you breastfeeding?

- ❑ YES
- ❑ NO

Do we have permission to import medications from your pharmacy?

- ❑ YES
- ❑ NO

Medications:

(Please list all Medication, including over the counter and Supplements.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

- ❑ NO CURRENT MEDICATIONS

Medical Allergies:

1. _____
2. _____
3. _____
4. _____

- ❑ NO CURRENT ALLERGIES

PRIVACY POLICY ACKNOWLEDGEMENT FORM

The notice of privacy practices for the office of Medovate, LLC is available at the front desk. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1 - Acknowledgement:

I acknowledge and understand the Notice of Privacy Practices for Medovate, LLC

_____ _____

Patient Name Date of Birth

Section 2 - Notification and Emergency Designee

To maintain continuity of care, I give Permission to Medovate, LLC and staff to:

- Confirm/revise my appointment times by (Please choose one only):
  - ❑ PHONE_____
  - ❑ TEXT_____
  - ❑ EMAIL_____

- Leave a message with normal test results on my voicemail.
  - ❑ YES
  - ❑ NO

- Discuss medical issues , including normal test results, with a designated person in my household.
  - ❑ YES_____
    Designated Person: Name and Relationship

  - ❑ NO

- In the event of an emergency, the office and personnel are authorized to contact the party listed below to discuss and handle medical care.

  _____
  Emergency Contact: Name, Phone Number and Relationship

Section 3- Communications

Medovate, LLC communications consists of sharing information on new products, services or promotions directly with you, our patient. We do not sell your information to third party companies.

- ❑ I wish to OPT IN and receive Medovate communications via email.

  _____
  EMAIL
- ❑ I wish to OPT OUT and do not wish to receive Medovate communications via email.

I Understand the information provided to me in the privacy notice and I have indicated my response to questions in each section.

Patient Signature:_____ Date: _____

PATIENT INFORMATION

Name_____
Last First Middle
Mailing Address:
_____
Street City State Zip Code
Cell Phone ( )_____ Home Phone ( )_____ Work Phone ( )_____
(Preferred)
Email Address:_____
Date of Birth ___/___/___ Last 4 of SS#_____ Marital Status _____ Spouse's Name_____
Age___ Sex ___ Race _____ ⏭ Employed ⏭ FT Student ⏭ PT Student ⏭Retired ⏭Unemployed

NAME OF RESPONSIBLE PARTY (If different from patient above)

Mailing address of responsible party
_____
Street City State Zip Code
Cell Phone ( )_____ Home Phone( )_____ Date of Birth__/__/__ Relationship_____
(Preferred)
IN CASE OF EMERGENCY, NOTIFY_____ PHONE ( )_____

INSURANCE INFORMATION

After completing this form, please bring it to the front desk with your current insurance card and photo ID.

PATIENT AUTHORIZATION

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the provider. I understand the Medovate, LLC uses photographs at times to ensure patient safety practices. I understand that Medovate, LLC does not permit taking videos, pictures, or audio recordings during any of my patient care. I understand that backless chairs or chairs on wheels in the exam rooms are intended for use by providers or medical staff only.

I understand that payment is required for all services at the time they are rendered(unless I participate in an insurance plan that Medovate, LLC accepts where all applicable copayments will be collected at the time of service). It is patient's responsibility to check to see if the Medovate, LLC provider is in-network. I am responsible for knowing the policies of my insurance, such as: copay coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc. Co-pays and self-pay procedures are due at the time of service, no exceptions. Medovate, LLC accepts payments in the form of Cash, Credit Card, or Check. I understand that if my check does not clear the bank a $25 service fee will automatically be added to my account. I understand that any procedure performed in the office may be billed separately and in addition to the office visit fee and that as of January 2015, pathology is now billed separately from the path lab.

I will do my best to notify the office if I am going to be late to my appointment and understand it will be up to the discretion of the Medovate, LLC provider as to whether or not i will be seen if arriving more than 15 minutes late. I also understand that I am responsible for a $30 charge for all missed appointments that i did not cancel at least 24 hours in advance. For the consideration of other patients who want to be seen, if I repeatedly cancel less than 48 hours in advance or repeatedly no show for my appointments, I understand that Medovate, LLC has the right to discharge me as a patient.

My signature below signifies my understanding and willingness to comply with the above policies.
Patient or Responsible party's signiture_____ Date ___/____/_____
If patient is a minor, Print name of responsible party: _____ Relationship_____

OFFICE POLICIES

Dear Valued Patient,

Thank you for choosing our practice. Please take a moment and review our office policies to ensure that you are aware of your patient rights and responsibilities in regard to insurance, scheduling, and other important office policies.

1. It is the patient's responsibility to confirm that the provider is in-network for their insurance.
2. If an insurance policy requires a referral. It is the patient's responsibility to bring the referral to the office visit. Referrals are valid for 90 days from the issue date and are good for as many visits as the primary doctor has improved.
3. The patient is responsible for knowing the policies of their insurance, such as copay, co-insurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc.
4. Copays ad payment for self-pay procedures are due at the time of service.
5. Each scheduled appointment in our office is considered an office visit and will be charged to the patient's insurance, with the exception of suture removal appointments.
6. If a procedure is performed during an office visit, it is an additional charge to the patient's insurance.
7. If a biopsy or excision is performed, the specimen will be sent top the laboratory and read by a Dermatologist. There is an additional charge for the laboratory service billed by the lab.
8. If you need need to cancel and/or reschedule an office visit or surgery appointment, please notify the office no less than 24 hours in advance. If you cancel less than 24 hours in advance or miss your appointment without notification, your account will be charged $30 for an office visit or $100 for a surgery appointment.
9. If you need need to cancel and/or reschedule a cosmetic procedure, please notify our office no less than 24 hours in advance. IF you cancel less than 24 hours in advance or miss your appointment without notification, your account will be charged $100 for a Cosmetic appointment.
10. Please call our office if you will be more than 15 minutes late for your appointment. It will be up to the discretion of the provider to determine whether the appointment will need to be rescheduled.

_____

Patient Name **Patient Signature** **Date**