Patient Name:________________________ DOB: ____/____/____ Date: ____/____/____

Past Medical History (PMH)

- ❏ Anxiety
- ❏ Arthritis
- ❏ Asthma
- ❏ Atrial fibrillation (irregular heartbeat)
- ❏ BPH (enlarged prostate)
- ❏ Cerebrovascular accident
- ❏ Chronic Obstructive Lung Disease (COPD)
- ❏ Coronary arteriosclerosis
- ❏ Depressive disorder
- ❏ Diabetes
- ❏ Disease caused by COVID-19
- ❏ Elevated blood pressure
- ❏ End Stage Renal Disease (ESRD)
- ❏ Epilepsy
- ❏ GERD (gastric reflux)
- ❏ H/O hypertension
- ❏ Hearing Loss
- ❏ HIV/AIDS
- ❏ Hypercholesterolemia (high cholesterol)
- ❏ Hyperthyroidism
- ❏ Hypothyroidism
- ❏ Leukemia
- ❏ Liver disease
- ❏ Lymphoma
- ❏ Malignant tumor of ___________________
- ❏ Radiation treatment
- ❏ Stroke
- ❏ Transplantation of bone marrow
- ❏ Other ______________________________
- ❏ NONE

Past Surgeries HIstory (PSH)

- ❏ Abdominoperineal resection
- ❏ Bilateral replacement of knee joints
- ❏ Biopsy of breast
- ❏ Biopsy of prostate
- ❏ Coronary artery bypass graft
- ❏ Entire transplanted kidney
- ❏ Excision of basal cell carcinoma
- ❏ Excision of squamous cell carcinoma
- ❏ Excision of melanoma
- ❏ Colostomy
- ❏ Tubal ligation
- ❏ Appendectomy
- ❏ Bilateral mastectomy
- ❏ Cholecystectomy
- ❏ Colectomy
- ❏ Liver excision
- ❏ Percutaneous transluminal Coronary angioplasty.
- ❏ Tissue graft heart valve replacement
- ❏ Total cystectomy
- ❏ History of transurethral prostatectomy
- ❏ Hysterectomy
- ❏ Kidney biopsy
- ❏ Kidney stone removal
- ❏ Lower anterior resection of rectum
- ❏ Lumpectomy of breast: L __ R __
- ❏ Mastectomy: L __ R __
- ❏ Mechanical heart valve replacement
- ❏ Oophorectomy
- ❏ Pancreatectomy
- ❏ Prosthetic arthroplasty of bilateral hips
- ❏ Shunt operation
- ❏ Splenectomy
- ❏ Surgical biopsy of skin
- ❏ Total nephrectomy
- ❏ Total orchiectomy
- ❏ Total replacement of hip: L __ R __
- ❏ Total replacement of knee: L __ R __
- ❏ Transplantation of heart
- ❏ Transplantation of liver
- ❏ Other:___________________________
- ❏ NONE

Skin conditions

- ❏ Acne
- ❏ Actinic keratosis
- ❏ Asteatosis cutis
- ❏ Basal cell carcinoma
- ❏ Blistering sunburns
- ❏ Dysplastic moles (nevi)
- ❏ Eczema
- ❏ Flaking or itchy scalp
- ❏ Hay fever/ allergies
- ❏ Psoriasis
- ❏ Squamous cell carcinoma
- ❏ Other: ______________________________
- ❏ NONE

Skin protection

Do you wear sunscreen?

- ❏ YES. What SPF do you apply?______
- ❏ NO.

Do you tan in a tanning salon?

- ❏ YES
- ❏ NO

Melanoma history

Do you have a history of melanoma? ❏ YES ❏ NO

Do you have a family history of melanoma

- ❏ YES. Which relative(s)?: _____________________
- ❏ NO

Medications

Please list all medications, including dose and frequency. Also include any over the counter medications and supplements.

1. ____________________ 7. ________________________
2. ____________________ 8. ________________________
3. ____________________ 9. ________________________
4. ____________________ 10. ________________________
5. ____________________ 11. ________________________
6. ____________________ 12. ________________________

MEDOVATE®

MEDICAL INNOVATION WITH A CONSCIENCE

❏ NO CURRENT MEDICATIONS

3.____________________ 9. _______________________
4.____________________ 10. _______________________
5.____________________ 11. _______________________
6.____________________ 12. _______________________

Medication allergies

1. ____________________ 7. _______________________
2. ____________________ 8. _______________________

❏ NO KNOWN DRUG ALLERGIES

Social History: alcohol use

How many times have you had 4 or more drinks in a day over the past year: ____________

Female patients only

Are you Pregnant? ❏ YES ❏ NO
Are you planning a pregnancy? ❏ YES ❏ NO
Are you breastfeeding? ❏ YES ❏ NO

Social History: tobacco Use

❏ Current tobacco user (cigarettes, chewing tobacco)
❏ Former tobacco user
Quit date: ____/____/____
Total years of usage: ______
❏ Never user

Pneumonia vaccine

For patients 65+, did you receive the Pneumonia Vaccine?
❏ YES
❏ NO
❏ UNKNOWN

Experienced the following recently:

❏ Fever/chills
❏ Unintentional weight loss
❏ Night sweats
❏ Headaches
❏ Dry, itchy eyes
❏ Blurry vision
❏ Frequent nose bleeds
❏ Depression
❏ Joint aches
❏ Muscle weakness
❏ Abdominal pain
❏ nausea/vomiting
❏ Diarrhea
❏ Cough
❏ shortness of breath
❏ Burning with urination
❏ Changing, bleeding, or itching mole//esion
❏ Rash
❏ Itching
❏ Burning skin
❏ Seizures
❏ Chest pain
❏ Sore throat
❏ Cough
❏ Sore throat
❏ Bloody stool
❏ Problems healing
❏ Hay fever
❏ Heat or cold intolerance
❏ Fall risk – use of a wheelchair, walker, cane
❏ NONE

Alerts

❏ History of passing out (vasovagal)
❏ Allergy to lidocaine
❏ Rapid heartbeat with epinephrine
❏ Allergy to adhesive
❏ Allergy to topical antibiotics
❏ Allergy to penicillin (PCN)
❏ Allergy to other oral antibiotic
❏ Allergy to latex
❏ Pacemaker
❏ Artificial joint paced in last two years
❏ Artificial heart valve
❏ Antibiotic prophylaxis prior procedures
❏ Organ Transplant Recipient (OTR)
❏ Immunosuppressed (low immunity)
❏ Anti-coagulated (on blood thinners)
❏ History of MRSA
❏ History of C. diff (GI infection)
❏ HIV/AIDS
❏ Hepatitis C
❏ History of TB
❏ Problems with scarring (keloids)
❏ Problems with bleeding
❏ Urine in blood
❏ Divots from Intralesional Kenalog (ILK)
❏ Thyroid problems
❏ History of atrial fibrillation
❏ Arrhythmia (irregular heartbeat)
❏ Defibrillator
❏ History of lymphoma/Leukemia
❏ Stomach upset with antibiotics
❏ Yeast Infection with antibiotics
❏ Stomach upset with antibiotics
❏ History of Deep Vein Thrombosis
❏ Coronary Artery Disease (CAD)
❏ History of CVA (e.g. brain bleed, stroke)
❏ History of a heart attack
❏ Stent placed
❏ Problems with UV phototherapy
❏ Problem with topical corticosteroids
❏ Motor disorder
❏ Hard of hearing
❏ History of cold sores

MEDOVATE®
MEDICAL INNOVATION WITH A CONSCIENCE

Primary Care Physician

Name:___________________________
Phone:___________________________
Referred to our practice? YES / NO

Prefered pharmacy

Pharmacy name:___________________
Phone number:____________________
Zip code: _____________
Permission to import meds: ❏ YES ❏ NO

How did you hear about us?

❏ Physician:_____________________
❏ Family: ______________________
❏ Friend:_______________________
❏ Insurance referral: _______________
❏ Google: ______________________
❏ Social media: __________________
❏ Other:________________________

Advanced Care Plan: For patients 65 and older

Do you have a health care proxy? ❏ YES ❏ NO
If yes, what is their name and phone number? ___________________________

Do you have a living will? ❏ YES ❏ NO

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

Signature: ____ DOB: _____ / _____ / ______

Section 2 - Notification and Emergency Designee
To maintain continuity of care, I give permission to Medovate, LLC for the following:

- Confirm and or revise my appointment times by (and please circle your preferred option): :
  - ❏ Phone
  - ❏ Text
  - ❏ Email
- Leave messages with test results? ❏ YES ❏ NO
- Discuss medical issues, including test results, with your designated person(s)?

  ❏YES ❏ NO

Designated Person(s): ____

Relationship: ____

- 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, relationship):_______________________________

____

Section 3 - Communication with Medovate

Medovate prefers to be able to communicate digitally with you on matters like updates to our practice (e.g. when a new practitioner joins our team or with changes to one of our offices (e.g. a change in location, new devices (technology).

- We do NOT and will NEVER sell your information to third party companies.

I wish to: ❏ opt IN ❏ opt OUT

PATIENT INFORMATION

____

Last Name First Name Middle Name

____

Street City State Zip Code

Mobile Phone: _______________________________ Home Phone: _______________________________

Email: ____________________________________ Date of Birth: _______/_______/_______

Marital Status: _______________________________ Significant other's name:_______________________

Preferred pronouns: ____

RESPONSIBLE PARTY (If different from patient information above)

____

Last Name First Name Middle Name

____

Street City State Zip Code

Relationship: ____

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 the 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 understand that my de-identified medical information may be used for research purposes at Medovate (e.g. in academic studies and continuous quality improvement projects. Only de-identified data will be used in the pursuit of furthering treatment, health outcomes as well as the experience of patients, staff and practitioners as Medovate builds a Clinically Integrated Network (CIN) to improve care and offer more value to the community.

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 $50 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.

For good and valuable consideration, the receipt and sufficiency of which I hereby acknowledge, I hereby grant to Medovate, L.L.C. and its officers, employees, agents, licensees, successors and assigns, (hereinafter collectively referred to as the “Practice”) the unrestricted, perpetual, worldwide, royalty-free right to use my name, likeness, testimonials, feedback, blogs, posts, and photographs or videos which depict me or in which I may be included, with the absolute right to make changes or alterations thereto, for advertising, promotion, trade, or any other lawful purposes, in any media or embodiment, now known or hereafter to become known, including, but not limited to, the reproduction, display, exhibition or posting thereof on the Practice's website, or in newsletter articles, brochures, posters, promotional items, or any other printed or electronic materials or any of its social media accounts. I acknowledge that I am entitled to certain protections under the Health

Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder, as the same may be amended from time to time, and other federal, state and local laws protecting my privacy, and that by granting these rights to the Practice, I am waiving such protections and do so voluntarily, knowingly and without coercion or fear of retribution for not granting these rights to the Practice.

I represent that I have the right to grant the Practice the usage rights set forth above and agree to hold the Practice harmless from any claims asserted by any third party alleging a violation of his, her or its rights in connection with any such uses.

I hereby warrant that I am of full age and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

Patient:

____
Signature

____
Printed Name

If the patient is a minor, please print the name of the responsible party:

____
Signature

____
Printed Name

____
Relationship to the patient:

MEDOVATE'S OFFICE POLICIES & PATIENT RIGHTS

Please take a moment and review our office policies for Medovate to ensure that you are aware of your patient rights and responsibilities in regard to health 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. We would like to tailor our treatment and overall care/experience with Medovate so we are best aligned with your temperament, values and background. We cultivate an inclusive environment at Medovate and ask that all members of our healthcare ecosystem (patients, staff and practitioners) be treated with respect and dignity at all times. We are all doing our best and appreciate your choosing our practice.

3. If an insurance policy requires a referral, it is the patient's responsibility to bring the referral to the office visit. Many referrals are valid for 90 days from the issue date and are good for as many visits as the primary doctor has improved.
4. 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.
5. Copays and payment for self-pay procedures are due at the time of service.
6. 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.
7. If a procedure is performed during an office visit, it is an additional charge to the patient's insurance.
8. If a biopsy, excision or other procedure is performed, the specimen(s) will be sent to the laboratory and read by a dermatopathologist and/or pathologist. There is an additional charge for the laboratory service billed by the lab.
9. If you 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 $50 for an office visit or $100 for a surgery appointment.
10. If you 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, you will be charged $100 for a cosmetic appointment.
11. 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 practitioner to determine whether the appointment will need to be rescheduled, but we will do our best to accommodate you.
12. Please let us know if there's anything you'd like to share with our team. An email to contact-us@medovate.io would be most appreciated. We are always looking to grow and improve so please let us know what we can do better. Our aim at Medovate is to reimagine healthcare, one patient at a time so together, we can heal each other.
13. Thank you for choosing our practice, there is no greater compliment.

My signature below signifies my understanding and willingness to comply with the above policies.

Patient (or responsible party's signature): ________________________________ Date: ____/____/_____

If the patient is a minor, please print the name of the responsible party: ___________________________

Relationship to the patient: ____

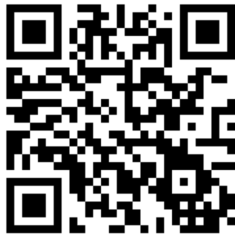
OPTIONAL SECTION

Section 4 - Patient-centered care

Medovate's primary goal is to demonstrate improved experiences and health outcome measures for all members of our healthcare community: patients, staff and practitioners. As such, we'd love to get to know you better so we tailor our care to fit your values, temperament, and cultural background. If you're willing to share this information with us, please do. If not, we completely understand.

- Your top 3 values (so we can better serve your needs):
  - ____
  - ____
  - ____

- Temperament—to help us better understand your personality or innate nature:
  - Myers-Brigg (32 questions for 16 personality types) ____________________
  - Enneagram (9 personality test): _____________________________________
  - PACE color palette (4: red, blue, yellow, green)_________________________



Myers-Brigg

Enneagram

PACE

- Cultural background—customs vary depending on how you're brought up. If you're comfortable, please share any info you'd like us to know about your culture, ethnicity, religion, profession, nationality, etc.
  - ____
  - ____
  - ____

- Please circle where you feel you fit on these scales:
  - Extraversion 0 ____________________ 50 _________________100%
  - Negative emotionality 0 ____________________ 50 _________________100%
  - Agreeableness 0 ____________________ 50 _________________100%
  - Conscientiousness 0 ____________________ 50 _________________100%
  - Openness to new ideas 0 ____________________ 50 _________________100%