Anne Arundel DERMATOLOGY
and Affiliate Practices

PATIENT ACCOUNT NO.

Patient Information Record
Please PRINT All Information

DATE

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MI)			SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL or ALTERNATE PHONE	
EMAIL ADDRESS:			

SEX	MARTIAL STATUS	AGE	DATE OF BIRTH	HAVE YOU EVER BEEN A PATIENT IN THIS OFFICE BEFORE
☐ Male ☐ Female	☐ Married ☐ Single ☐ Legally Separated ☐ Divorced ☐ Unknown ☐ Widowed			☐ Yes ☐ No IF YES, WHEN?

OCCUPATION	EMPLOYER
WORK ADDRESS	
SPOUSES NAME (LAST, FIRST, MI)	SPOUSES DATE OF BIRTH

STUDENT STATUS Full Time Part Time Not a Student	PRIMARY CARE PHYSICIAN	ADDRESS	PHONE

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME		RELATIONSHIP
ADDRESS		
OCCUPATION	EMPLOYER	PHONE
ADDRESS		WORK PHONE

POLICY HOLDER INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER	
GROUP #	CERTIFICATE/POLICY/ ID#	POLICY HOLDERS DATE OF BIRTH
MEDICARE #	MEDICAID #	POLICY HOLDER'S SOCIAL SECURITY NUMBER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER	POLICY HOLDER'S SOCIAL SECURITY NUMBER
GROUP #	CERTIFICATE / POLICY / ID #	POLICY HOLDERS DATE OF BIRTH

Assignment of Benefits:

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/ or all commercial payors to make payments on my behalf directly to Anne Arundel Dermatology. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

Signed _____ Date _____

***A fee may be incurred for No Show and/or cancellation without required notice. Initial _____ Date _____ ***

How did you hear about Anne Arundel Dermatology, P.A. and Affiliate Practices

☐ Radio ☐ Insurance Website ☐ Magazine ☐ Google Search ☐ Social Media ☐ Family/Friend ☐ Physician Referral ☐ Other: _____

Anne Arundel DERMATOLOGY
and Affiliate Practices

Patient Name: _____

Date of Birth: _____

General Consent/Agreement to Outpatient Services

This form applies to all Anne Arundel Dermatology practice sites. This form must be completed by all new patients and then, at least annually or when the patient's insurance changes.

1. **CONSENT TO TREATMENT:** I consent to receive medical and/or cosmetic health care services provided by Anne Arundel Dermatology (AADerm") entities. I understand that such services may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2. **PAYMENT FOR SERVICES**: I understand that AADerm may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Anne Arundel Dermatology . If I should receive the payments, I understand that I will be responsible for paying AADerm. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. I understand that AADerm will hold me responsible in any one of the following situations

    a. When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
    b. When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
    c. When my health plan does not participate with AADerm for the services I want or need and I agree to pay for my care myself.
    d. When I receive services that are not covered under my health plan including cosmetic services.

    If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have AADerm act on my behalf to obtain my benefits when AADerm asks to do so. I also agree that AADerm can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

    I understand if I do not show up for a scheduled visit and do not notify the office, I will pay a NO SHOW fee of $50.00. If I cancel my appointment in advance or on the day I am scheduled, my appointment will be rescheduled without a fee. If I repeatedly cancel, a cancellation fee may be charged.

3. **CONSENT TO PHOTOGRAPH:** I understand photographs, videotapes, digital and/or other images may be made/recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

4. **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to AADerm for the purpose of continued treatment.

5. **MY PERSONAL BELONGINGS:** I understand that I am responsible for my personal belongings and valuables.

6. **RELEASE OF INFORMATION:** I authorize AADerm practice site(s) to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information from or regarding prior encounter(s) at other AADerm practice locations may be made available to subsequent AADerm-affiliated sites to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
    If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES to FAMILY and FRIENDS: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

7. **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT:** I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for AADerm and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of AADerm. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

   You may be contacted via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

   Home Phone: _____. Cell Phone: _____

   Authorized email address: _____.

   OR

   _____ (Initials) I decline to receive communication via text.

   _____ (Initials) I decline to receive communication via email.

Revocation

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via text

__I hereby revoke my request to receive any future appointment reminders, feedback, marketing, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: Time:

8. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received/reviewed AADerm's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I agree to the items as outlined in the Agreement.

Name (Print): _____ Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative): _____

Anne Arundel DERMATOLOGY
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Date: _____ **DOB:** _____ **MRN:** _____

Patient Name: _____

Referring Provider: _____

MEDICATION ALLERGIES: _____

_____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Pharmacy Address: _____

MEDICAL HISTORY AND INTAKE FORM

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat) Bone Marrow Transplantation
BPH (Enlarged Prostate)
Cancer: Type(s) _____
_____
_____
COPD (Chronic Obstructive Pulmonary Disease)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal (Kidney) Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis/Liver Disease
Hypertension(High Blood Pressure)
HIV/AIDS
Hypercholesterolemia (High Cholesterol)
Hyperthyroid (Overactive Thyroid)
Hypothyroid (Underactive Thyroid)
Radiation Treatment
Seizures
Stroke
None
OTHER: _____
_____

Have You Had Surgery On Any Of The Following Organs: (Please circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Lumpectomy (Both Breasts)
Breast: Lumpectomy (Left Breast)
Breast: Lumpectomy (Right Breast)
Breast: Mastectomy (Both Breasts)
Breast: Mastectomy (Left Breast)
Breast: Mastectomy (Right Breast)
Breast: Breast Biopsy
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gall Bladder(Cholecystectomy): Removed
Heart: Coronary Artery Bypass Surgery
Heart: PTCA(Coronary Angioplasty)
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement: Knee (Both)
Joint Replacement: Knee (Left)
Joint Replacement: Knee (Right)
Joint Replacement: Hip (Both)
Joint Replacement: Hip(Left)
Joint Replacement: Hip(Right)
Kidney: Kidney Biopsy
Kidney: Nephrectomy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Liver: Shunt
Liver: Liver Transplant
Liver: Hepatectomy
Ovaries(Oophorectomy): Endometriosis
Ovaries(Oophorectomy): Ovarian Cyst
Ovaries(Oophorectomy): Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas: Pancreatecomy
Prostate(Prostatectomy): Prostate Cancer
Prostate(Prostatectomy): Prostate Biopsy
Prostate:TURP(Transurethral Resection of the Prostate)
Rectum: APR(Abdominoperineal Resection)
Rectum: Lower Anterior Resection
Skin: Biopsy
Skin: Basal Cell Carcinoma
Skin: Squamous Cell Carcinoma
Skin: Melanoma
Spleen (Splenectomy)
Testicles(Orchiectomy)
Uterus(Hysterectomy): Fibroids
Uterus(Hysterectomy): Uterine Cancer
Uterus(Hysterectomy): Cervical Cancer

OTHER: _____

*****Please fill in reverse side of sheet also*****

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis (pre-cancerous lesions)
Asthma
Basal Cell Skin Cancer
Blistering Sun Burns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/ Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell 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 **Melanoma**? If yes, which relative(s)? _____

Social History:

Smoking Status: (Please circle one)
Current every day smoker
Current some day smoker: Tobacco
Current some day smoker: Cigarettes
Former Smoker
Never Smoker
Smoker: Current status unknown
Unknown if ever smoked
Heavy tobacco smoker
Light tobacco smoker

Alcohol Status: (Please circle one)
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Occupation: _____

Hobbies: _____

Family History:(please check all that apply)

Acne	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Arthritis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Asthma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Eczema	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Hay Fever/Allergies	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Lupus	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Psoriasis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None
Non-Melanoma Skin Cancers	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Other	☐ None

Review of Systems: Do you have or are you currently experiencing any of the following? (Please circle yes or no)

Changing mole	Yes	No	Muscle weakness	Yes	No
Rash	Yes	No	Neck Stiffness	Yes	No
Fever or chills	Yes	No	Headaches	Yes	No
Depression	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Cough	Yes	No
Problems with healing	Yes	No	Shortness of breath	Yes	No
Problems with bleeding	Yes	No	Wheezing	Yes	No
Problems with scarring (hypertrophic or keloid) Immunosuppression	Yes	No	Pacemaker	Yes	No
	Yes	No	Defibrillator	Yes	No
Hay fever	Yes	No	Blood thinners	Yes	No
Chest pain	Yes	No	GI upset with antibiotics	Yes	No
Night sweats	Yes	No	Allergy to adhesive	Yes	No
Unintentional weight loss	Yes	No	Allergy to lidocaine	Yes	No
Thyroid problems	Yes	No	Allergy to topical antibiotic ointments	Yes	No
Sore throat	Yes	No	Artificial heart valve	Yes	No
Blurry vision	Yes	No	Artificial joint within the past 2 years	Yes	No
Abdominal pain	Yes	No	MRSA	Yes	No
Bloody stool	Yes	No	Premedication prior to procedures Rapid heartbeat with epinephrine	Yes	No
Bloody urine	Yes	No		Yes	No
Joint aches	Yes	No	Pregnancy or planning a pregnancy	Yes	No

Immunizations: Have you had the following immunizations?

Vaccine:	**Date of Vaccination (can be approximate if unsure):**
Influenza (Flu)	_____
Pneumonia	_____
Varicella (Shingles)	_____

Anne Arundel
DERMATOLOGY
and Affiliate Practices

To Parents and Guardians of Minor Children:

The providers and staff of Anne Arundel Dermatology, P.C. ("AAD") place great emphasis on the health and well-being of each and every patient that comes to our offices. We appreciate that you have entrusted us to provide dermatology services to your minor child and we look forward to working with you to ensure that your child receives the best health care possible.

Please see the Consent to Treat a Minor form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child as necessary. This consent form will remain in effect until revoked in writing. You may request this form from any member of our office staff.

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). You will be asked to sign the authorization for treatment on or before the first visit, and to come to the office for as many visits as possible. The authorization allows you to approve: a) a course of therapy for your child with your participation and consent; b) that other responsible adults that you name may bring your child to the office; c) that we treat your adolescent child when s/he comes to the office unaccompanied by a responsible adult; and, d) that we can help in a health emergency. If your minor child presents to the office unaccompanied, we will check that you have signed the authorization to treat your adolescent child in your absence, and will reschedule if we do not have your written approval. If the minor presents in the company of an adult other than a parent or legal guardian, we will check that they are the persons named in the authorization; or that you have otherwise authorized in writing your consent.

Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present a photo ID upon checking the patient in for the appointment. If consent documentation or photo identification is missing, the appointment will be rescheduled.

By law, minors have the right to consent to health care under specific circumstances. For the purposes of dermatology care, a minor may consent to care if s/he is married, or is self-supporting regardless of income. A minor who is also a parent may consent to treatment for his or her child, even if the parent is under age 18.

It is the philosophy of this medical practice to encourage minor patients to include a parent, guardian or other trusted adult in all aspects of their health care. If you have questions regarding any of this information, please contact your child's treating physician.

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Consent to Treat a Minor

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

I, the undersigned, parent(s) or legal guardian of the above named patient, a minor, do hereby authorize the physicians, physician assistants, and nurse practitioners, at any Anne Arundel Dermatology, P.C. ("AAD") practice site to provide healthcare services as outlined in the General Agreement to Outpatient Services, including assessment, planning, diagnosis and treatment approved by a supervising physician who is licensed to practice in the state where the minor's healthcare service is being rendered.

In an emergency, it is understood that authorization is granted to the physicians, physician assistants, and nurse practitioners at AAD to provide emergency care, treatment, and/ or hospital referral which is deemed necessary in the exercise of his or her best judgment.

Consent to Treat a Minor Child accompanied by an adult other than the child's parent or legal guardian.

I, the parent or legal guardian of the patient named above, do hereby authorize the physicians at AAD to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

☐ I authorize my adolescent child to be treated at the office visit(s) if I am unable to attend.

This authorization is valid:

☐ For any and all medical treatment.
☐ For today only.
☐ For this specific problem(s) or a specific date range. Please specify:

This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.

Parent or legal guardian: (Print Name) _____ Date: _____ /____ / ____

Parent or legal guardian signature: _____

Witness: (Print Name) _____ Signature: _____

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Today's Date: _____

Medications:

Please list all current medications including prescriptions, over-the-counter medications, vitamins, minerals and supplements. **If not currently on medications, write NONE or N/A.**

☐ Please check box and do not fill out medication list if you have been seen in the last 6 months **AND** you gave us your medication list at that time **AND** your medication list has not changed.

Name of Prescribed Medication	Dose	Route	Frequency
Example: Lipitor 20 mg	1 tablet	Orally	Once a day

Over the Counter Medication	Dose	Route	Frequency
Example: Fish Oil 1000 mg	1 tablet	Orally	Once a day

Patient Name: _____ **DOB:** _____

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MIPS Questionnaire

Today's Date: _____

Patient Questionnaire

1. Are you a tobacco **smoker**? **Current / Former / Never**
   (Please circle answer)

2. Have you received an Influenza Vaccine during flu season (August 2019-March 2020 or August 2020-March 2021)? **Yes / No**

   If NO, select reason why: **Refused / Allergy**

For Patients 65 years and older

3. Have you ever had a Pneumonia Vaccine (Prevnar 13 and/or Pneumovax 23)?
   Yes / No *(Please circle answer)*

4. Do you have a health care proxy in the event you are unable to make your own medical decisions? **Yes / No** *(Please circle answer)*

5. Do you have a living will? **Yes / No** *(Please circle answer)*

6. Which statement(s) best reflects your wishes on advanced care recommendations? *(Please check all that apply)*

   ☐ **Do Not Intubate**: I do not wish to have a breathing tube, even if it is necessary to save my life.

   ☐ **Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

   ☐ **Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation efforts to be made.

Patient Name: _____ **DOB:** _____

Primary Care Physician: _____

Anne Arundel DERMATOLOGY

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Patient Portal Access

Please Share your email address with us so you can access these great features:

- Communicate with your provider via email
- View your visit notes
- Update your medication list
- Update your medical history
- View patient education materials
- Add your favorite pharmacy for electronic Rx

*Within 24 hours you will receive an email stating “A request was made to activate your patient portal with Anne Arundel Dermatology and Affiliate Practices”

*Please follow the links in the email to set up your patient portal. The link will expire in exactly 24 hours after receiving the email. Please contact our office at (443) 351- DERM if your link expires before you active your account.

**The email will come from Modernizing Medicine which is our electronic medical software*

- -

Patient Portal Consent

Last Name: ________________________ First Name: ________________________

Date of Birth: ____/____/____ Email Address: __________________________

☐ Please do not send me occasional announcements and offers from Anne Arundel Dermatology

☐ Please check if you wish to decline the patient portal.

Signature: __________________________ Date: ____/____/____________