nd

novi
dermatology

Patient Name: _____

Date of Birth:_____

Today's Date:_____

NEW PATIENT REGISTRATION

Street Address:_____ Apt #:_____

City, State: _____ Zip:_____ Gender: M F

Emergency Contact: _____Emergency Contact Phone:_____

Preferred Contact Phone Number: _____☐ Home ☐ Work ☐ Cell

Alternate Contact Phone Number: _____☐ Home ☐ Work ☐ Cell

Have you been seen by a dermatologist in the past 3 years? ☐ YES ☐ NO

If yes, who did you see? ☐ Dr Barron ☐ Dr Swearingen ☐ Dr Watson ☐ Other: _____

How did you hear about us? _____

PREFERRED PHARMACY

Name: _____

Pharmacy Phone #:_____ Pharmacy City or Zip Code: _____

Primary Care Provider (PCP) Name: _____PCP Phone #: _____

Referring Provider, if different from PCP:_____Referring Provider Phone #:_____

☐ Sign me up for Modernizing Medicine Patient Portal. This portal will allow for electronic access to my health care information and communication with my physician's office in a safe, convenient way.

My email address is _____

OR ☐ Do not sign me up for Modernizing Medicine Patient Portal

List all insurances or ☐ No Insurance (Self-Pay)

Primary Insurance Company Name: (ie BCBS, BCN, Medicare, Aetna) _____

Insured's Name: _____ Insured's Relationship to Patient: _____

Insured's DOB: _____ Insured's Employer: _____

Secondary Insurance Company Name: _____

Insured's Name: _____ Insured's Relationship to Patient: _____

Insured's DOB: _____ Insured's Employer: _____

IF PATIENT IS A MINOR:

Parent/Guardian Name _____Parent/Guardian DOB:_____

Relationship to the patient: _____

Parent/Guardian Signature _____ Date:_____

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PATIENT MEDICAL HISTORY

Past Medical History: Select any of the medical conditions that you have had in the past or are currently being treated for:

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Hypothyroidism (underactive thyroid)
- ☐ Radiation Treatment
- ☐ Inflammatory Bowel Disease (ie: Crohn's or Ulcerative Colitis)
- ☐ Lymphoma
- ☐ Heart Valve Replacement –Biologic
- ☐ Heart Valve Replacement – Mechanical
- ☐ Heart Transplant
- ☐ Joint Replacement: Indicate year replaced
  - ☐ Hip Both: _____
  - ☐ Hip Left: _____
  - ☐ Hip Right: _____
  - ☐ Knee Both: _____
  - ☐ Knee Left: _____
  - ☐ Knee Right: _____
  - ☐ Other: _____
- ☐ Organ Transplant:
- ☐ Liver Transplant
- ☐ Other: _____

OR

- ☐ I have no medical problems

Immunizations:

If over 65 yrs old, have you received a Pneumovax vaccine? ☐ Yes ☐ No

Have your received a flu (influenza) vaccine this season (answer only if Oct- March)? ☐ Yes ☐ No

Past Dermatologic History: Select any of the skin conditions that you have had in the past or are currently being treated for: ☐ **None or list below**

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Carcinoma
- ☐ Dysplastic Nevi
- ☐ Eczema
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma

Medications: ☐ **None or List your medications below**

Medication:	**Dose:**	**Frequency:**

Allergies: ☐ No known drug allergies OR list below allergy and reaction

- ☐ Latex: _____
- ☐ Erythromycin: _____
- ☐ Penicillin: _____
- ☐ Tetracycline: _____
- ☐ Local Anesthesia: _____
- ☐ Cephalexin (Keflex): _____
- ☐ Sulfa: _____
- ☐ Other (including foods): : _____

Family History: Do you have a family history of (check all that apply):

- ☐ Yes ☐ No Melanoma
- ☐ Yes ☐ No Basal cell carcinoma
- ☐ Yes ☐ No Squamous Cell Carcinoma
- ☐ Yes ☐ No Psoriasis
- ☐ Yes ☐ No Eczema

Smoking Status ☐ Never smoker OR fill out below

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Cigar Smoker

Date started smoking: _____

Date quit smoking: _____

# of packs per day: _____

Total years smoking: _____

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NEW PATIENT VISIT

What is the primary reason for your visit today? **(Check one)**

- ☐ Acne
- ☐ Cyst
- ☐ Rosacea
- ☐ Eczema
- ☐ Hair Loss
- ☐ Skin lesion
- ☐ Mole
- ☐ Skin tag
- ☐ Psoriasis
- ☐ Rash
- ☐ Itching
- ☐ History of skin cancer
- ☐ Skin cancer screening
- ☐ Other: _____

List other concerns you would like to address at a future visit, or if time allows at this visit:

Symptom Review: Do you have?

- ☐ a changing mole
- ☐ easy bleeding
- ☐ fevers or chills
- ☐ immunosuppression
- ☐ a rash today

Important Information for your Physician:

- ☐ Yes ☐ No Do you have a pacemaker, defibrillator or other implanted electrical device?
- ☐ Yes ☐ No Women: are you pregnant or planning pregnancy?
- ☐ Yes ☐ No Women: are you nursing?

What is a skin cancer screening?

A skin cancer screening is a visual inspection of your skin. At Novi Dermatology, we offer skin cancer screenings by board-certified dermatologists. **If an abnormal mole or skin growth is discovered, a biopsy may be recommended to evaluate for skin cancer.**

Why are skin cancer screenings necessary?

Skin cancer is the most common cancer in the USA; in fact, 1 in 5 Americans will develop skin cancer in their lifetime. People of all ethnicities can get skin cancer. Regular self-skin exams and a yearly dermatologist examination can help people find skin cancers early.

Who is at increased risk for skin cancer?

Below are only some of the factors can increase your future risk of skin cancer:

- blistering sunburns
- tanning bed use
- prior radiation exposure
- family history of skin cancer
- if you already have had a history of skin cancer
- immune suppression for any reason (ie: biologic medications such as Remicade /Humira, organ transplant, chronic lymphomas, or living with HIV/AIDS)

Why do I have to get undressed for a skin cancer screening? Skin cancer can develop on any part of the body. While sun exposure and ultraviolet light increase the risk of skin cancer, it is not the only thing that causes skin cancer, and skin cancer can develop in areas not exposed to the sun. While we recommend getting completely undressed, we respect your privacy, and you can follow the guidelines below for your skin exams:

Women: if you leave your bra on, we will ask before checking the breast area.

Women and Men: if you leave your underwear on, we will not check the genital area. However, unless you request otherwise, we will check the buttock and hip/groin area.

Are skin cancer screenings covered by my insurance?

Not all insurance companies cover skin cancer screenings, and policies are constantly changing. Please check with your insurance company.

Name: _____

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NOVI DERMATOLOGY, PLLC
PATIENT CONSENT AND AGREEMENT TO POLICIES

Novi Dermatology, PLLC (referred to herein as "Novi Dermatology," "we," "us," and/or "our") maintains the policies below. By signing this Patient Consent and Agreement to Policies, you agree to receive medical care and treatment from Novi Dermatology and its employed, contracted, and affiliated healthcare providers and you authorize Novi Dermatology to coordinate with your other healthcare providers on your behalf.

In an effort to facilitate Novi Dermatology's goal of maintaining an efficient schedule for all patients, we ask that you arrive 15 minutes before your scheduled appointment time to register and complete paperwork. You should contact the office immediately if you expect your arrival to be delayed or if you are unable to keep your appointment in light of unforeseen circumstances. In general, we request that you provide at least 48 hours' advanced notice of any cancellations. In the event of a late arrival, your appointment may need to be rescheduled.

You hereby agree that Novi Dermatology will not be liable for any failure to provide, or delay in providing, services to you in the event that Novi Dermatology and its providers are assisting another patient(s) in an emergency or in the event of other circumstances beyond the reasonable control of Novi Dermatology. **In the event of an emergency, or a situation in which you could reasonably expect an emergency to arise, you agree to call 911 or visit the nearest emergency room and follow the directions of emergency personnel.**

Novi Dermatology maintains a standard fee schedule, subject to change from time to time. We would be happy to discuss with you our current fees for proposed services at any time.

You agree that you are financially responsible for and will pay all incurred charges for all services and products provided by Novi Dermatology and its employees, contractors and providers. Payment is due within 30 days of the date provided in your statement. Payments not received after 30 days of the statement date will be assessed a late fee of $25. This fee will accrue at a rate of $25 per 30 days late. You understand that Novi Dermatology has the right to forward unpaid accounts to a collections agency and you agree to bear and reimburse Novi Dermatology for all costs associated with Novi Dermatology's collection efforts on your account. You agree that, in the event that any of your specimens are sent to a laboratory by Novi Dermatology, you will be directly billed by and solely responsible for paying that laboratory for all laboratory and related interpretation services performed regarding your specimen(s).

You must present current insurance information at each visit to Novi Dermatology. If you do not have your current insurance card and any referrals required by your insurance with you at the time of your visit, you should be prepared to pay for your visit on the same date of service. If you do not have your current insurance card and any required referrals and cannot provide payment on the date of service, we may ask you to reschedule your appointment. It is your responsibility to understand your insurance benefits including, without limitation, your copays, coverage and deductibles, and any required referrals.

If the services or products provided by Novi Dermatology are payable under an applicable insurance benefit, you hereby assign all payments and medical benefits directly to Novi Dermatology for the services rendered and products provided by Novi Dermatology that would otherwise be payable to you. You understand that this Policy imposes no obligation for Novi Dermatology to collect money on your behalf. Any deductibles or copays owed to Novi Dermatology pursuant to your insurance policy will not be waived. Unpaid copays and amounts subject to your deductible, if any, may be reported to your insurance carrier since it is a requirement of your insurance plan and may affect your insurance coverage.

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You understand that if no insurance coverage exists for any services or products that you receive from Novi Dermatology or your insurance provider(s) fails to pay Novi Dermatology, you are financially responsible for the incurred charges and you agree that the above paragraph does not release you from such responsibility. You further agree that you will pay all such incurred charges in accordance with Novi Dermatology's then-current payment policies and procedures.

Your signature below evidences your agreement to all of the terms set forth in this Patient Consent and Agreement to Policies and that you are the patient or are authorized to act on behalf of the patient to sign this Patient Consent and Agreement to Policies. You understand that your agreement is effective on the date signed below and that you may revoke your agreement in writing. Your revocation will not be effective for actions already taken by Novi Dermatology or that are in progress and will only be prospectively effective.

Patient Signature: _____ Date: _____

Alternative Consent Authority and Signature

Patient's Parent or Guardian: _____ Relation: _____

Patient's Parent or Guardian Signature: _____Date: _____

_____ _____

Witness Date