BARATTA
DERMATOLOGY

PATIENT MEDICAL HISTORY

Last Name _____ First Name _____ M.I.____D.O.B____/___/_____ Age _____

Home Address: _____ City:_____ State:_____ Zip Code:_____

Phone Number:_____

Primary Care Physician and Location:_____ _____

Pharmacy (name, city, and street): _____

Occupation: _____

Email: _____ Social Security #_____

Whom can we thank for your referral?

- Facebook
- Instagram
- Friend
- Doctor
- Insurance
- Other:_____

PAST MEDICAL HISTORY	YES	NO
Eczema		
Psoriasis		
Diabetes		
Heart disease		
Thyroid disease		
Sexually transmitted diseases		
Cancer (other than skin)		
High blood pressure		
High Cholesterol		
Tuberculosis		
Other conditions (please list): _____		

MEDICATIONS (name and dose)	
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

ALLERGIES (please list with reactions)	
1.	3.
2.	4.
5.	6.

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SOCIAL HISTORY	YES	NO
Do you smoke?		

SKIN CANCER/FAMILY HISTORY	YES	NO
Have you ever had basal cell carcinoma (BCC) ?		
Date/location/treatment:		
Have you ever had squamous cell carcinoma (SCC) ?		
Date/location/treatment:		
Have you ever had melanoma?		
Date/location/treatment:		
Any family members with melanoma?		
Date/location/treatment:		
Any family members with other skin cancer?		
List:		

SURGICAL HISTORY	YES	NO
Do you take Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, aspirin, fish oil, or other blood thinners? If yes:		
Do you have any artificial joints, heart valves, or other implanted material? If yes, please list:		
Do you routinely take antibiotics before dental procedures?		
Have you ever had a reaction to		
Do you have liver or kidney disease?		
Do you have a bleeding or clotting		
Do you have a pacemaker or defibrillator?		

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Surgeries (please list year performed)	
1.	3.
2.	4.
5.	6.

REVIEW OF SYSTEMS

For each question, check yes or no

CONSTITUTIONAL	YES	NO
Fever or chills		
Weight loss		
Night sweats		
Shortness of breath		
Cough		
Wheezing		
Abdominal pain		
Bloody stool/urine		
Problems with bleeding		
Thyroid problems		
Sore throat		

MUSCULOSKELETAL	YES	NO
Muscle weakness		
Neck stiffness		
Joint aches		
PSYCHIATRIC		
Depression		
Anxiety		
NEUROLOGIC		
Headache		
Seizures		
CARDIOVASCULAR		
Chest pain		
ALLERGIC/IMMUNOLOGIC		
Immunosuppression		
Hay fever		
EYES		
Blurry vision		

Please list any family members or other individuals we can discuss your medical information with other than yourself. Please include their full name, relationship, and phone number.

_____ _____

_____ _____

Are you interested in any of the following services?

- Botox
- Filler
- Laser Hair Removal
- Skin Care Products
- Photo Rejuvenation
- Chemical Peels
- Sculpsure
- Other:

To the best of my knowledge, the above information is accurate and complete.

Patient Signature:_____**DATE:** _____

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HIPAA / Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Baratta Dermatology to use and disclose Protected Health Information (PHI) about me in order to carry out health care treatment and payment operations. (The Notice of Privacy Practices provided herein by Baratta Dermatology describes such uses and disclosures more completely. To learn more about HIPAA, you may visit the website for the US Department of Health and Human Services at: http://www.hhs.gov/ocr/privacy

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Baratta Dermatology reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a request to Baratta Dermatology.

With this consent, I agree and acknowledge that Baratta Dermatology may:

•Call, email, text, and/or leave messages on voice mail at the numbers and email I have provided Baratta Dermatology regarding appointment reminders, insurance and billing items, and any other matters pertaining to my clinical care, including test results, etc.

•Speak to certain person(s) regarding any appointment reminders, insurance items, and any matters pertaining to my clinical care, including test results, etc. (Please list on the line below the name of family members or other person(s) with whom we may speak. Should you wish we only speak to you regarding your PHI, please state "Patient only")

_____

•Mail to my home address any items that may assist the practice in carrying out treatment, payment, and health care operations.

•Send electronic medication prescriptions to my pharmacy, and when available obtain medication history records to be downloaded into my electronic medical record.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, or if I later revoke it, Baratta Dermatology may decline to provide treatment to me.

_____ _____ _____

Signature of Patient or Legal Guardian Print Patient's Name Patient's Date of Birth

_____ _____

Print Name of Patient's Legal Guardian, if applicable Date

(The Patient/Legal Guardian may request a photocopy of this signed consent)

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Biopsy Consent

During your visit, you may require a biopsy. Please read and sign below to allow your physician to take a biopsy sample if necessary during your visit.

Rationale

A skin biopsy allows the dermatologist to test a lesion or rash under the microscope to obtain a diagnosis. It usually involves numbing the area with numbing medication, removing a small piece of skin. Wound care instructions will be provided to you at the end of your visit.

Risks and Complications Specific to Skin Biopsies/Excisions

- Bleeding
- Infection
- Pain
- Scar
- Incomplete Removal
- Recurrence
- Nerve Damage/Numbness
- Allergic reaction to anesthesia

The physician has explained to the patient/family/guardian the nature of the patient's condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches. The physician has discussed the likelihood of major risks or complications of this procedure including the specific risks listed above and (if applicable) drug reactions, hemorrhage, infection, complications from blood or blood components. The physician has also indicated that with any procedure there is always the possibility of an unexpected complication.

Signature:_____ Date:_____

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APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Baratta Dermatology. When you schedule an appointment with Baratta Dermatology we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- An established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $25.00 fee.

- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $50.00 fee.

- If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Baratta Dermatology.

- Any new patient who fails to show for their initial visit will be able to reschedule the visit without a fee, if the patient fails to show for their second time, a $50 fee will be charged.

- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our front desk staff who may be able to waive the No Show fee. You may contact Baratta Dermatology 24 hours a day, 7 days a week at 609-288-6884. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Date

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Statement of Patient Financial Responsibility

Patient Name: _____ Date of Birth: _____/_____/_____

Baratta Dermatology appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill. Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know your coverage and benefits.

You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at Baratta Dermatology

I authorize Baratta Dermatology to furnish information to insurance carriers concerning my care.
Initial _____

If any tests are performed by the lab you are financially responsible for any bill you may receive from their office. We use an experienced and trusted dermatology pathologist to review our biopsies. If you prefer to have your specimen reviewed by a general pathologist at a lab of your choice, you must let us know prior to your visit. If payment is denied for lack of authorization, I understand that I am responsible for payment in full.
Initial_____

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Some health insurance carriers require the patient to pay a copay for services rendered. This is a contract between you and your insurance carrier. Payment of all co-pays is expected at the time the service is rendered for the patients. I understand that I am responsible for co-payments and deductible/co-insurance as dictated by my insurance carrier.
Initial_____

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due.
Initial_____

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