Affiliated Dermatology®
20401 N. 73rd St., Suite 230, Scottsdale, AZ 85255
13995 W. Statler Blvd., Suite 150 Surprise, AZ 85374
41810 N. Venture Dr., Suite D-136 Anthem, AZ 85086
19646 N. 27th Ave, Suite 305, Phoenix, AZ 85027
1459 S. Higley Rd, Suite 106, Gilbert, AZ 85296
480-556-0446 phone 480-556-0447 fax

Today's Date ____________________

First Name ________________________ M.I. _____ Last Name ____________________________

Parent or Legal Guardian ____

Address ____ Apt #____________________

City __________________________________ State __________ Zip Code __________________

Home Phone ___________________ Work Phone _______________Other Phone ________________

Social Security Number _____________________ Date of Birth _________________ Male / Female

Email Address _______________________________________

Primary Care Physician Name and Phone Number ____

Did your PCP refer you? yes / no How did you hear of Affiliated Dermatology® ________________

INSURANCE INFORMATION
MUST BE COMPLETED - EVEN IF WE HAVE A COPY OF YOUR CARD!!

Primary Insurance ____________________

Policy Holder Name ______________________
(This is the person who pays for policy from their employer)

Policy Holder's ID# _______________________
(This is sometimes the social security number of the policy holder)

Group # _______________________________

Patient Relationship to Policy Holder
☐ self ☐ spouse ☐ daughter ☐ son

Secondary Insurance ____________________

Policy Holder Name ______________________
(This is the person who pays for policy from their employer)

Policy Holder's ID# _______________________
(This is sometimes the social security number of the policy holder)

Group # _______________________________

Patient Relationship to Policy Holder
☐ self ☐ spouse ☐ daughter ☐ son

In case of Emergency, who should be notified? ____
Name Relationship Phone Number

Pharmacy of Choice ____
Name Location Phone Number

PRIVACY POLICIES

We are required by law to provide you with a notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information as we describe them in our pamphlet.

Your signature below signifies that you have received our Notice of Privacy Practices for Protected Health Information.

____

Signature of patient or legal guardian   Date

____

Printed name of patient

May we leave confidential messages?

Yes/No   If yes please indicate the phone number and sign below.

____

Signature   Phone Number

Preferred method of contact regarding appointment reminders

Call (Landline) ______________________________

Text Message (Cell) ___________________________

Email ___________________________________

It is the practice of this office not to release your medical information to anyone without your written authorization. If you would like our office to discuss your confidential medical information with someone other than you (such as your primary care physician, spouse or family member) please list the person(s) and their relationship to you.

____   ________________

Printed Name of Authorized Person   Relationship

____   ________________

Printed Name of Authorized Person   Relationship

____   ________________

Printed Name of Authorized Person   Relationship

CANCELLATION POLICY

In the event that you schedule a surgical procedure and are unable to provide us with 24 hours notice of cancellation, you will be charged a $250 cancellation fee.

Should you schedule a routine office visit and are unable to provide us with 24 hours notice of cancellation, you will be charged a $50 cancellation fee.

FINANCIAL POLICY

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office. In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. We accept Visa and MasterCard for your convenience. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. **You will be responsible at the time of service for payment of: 1. Annual deductibles 2. Co-payments and/or 3. Charges for non-covered or cosmetic services.**

In the event that we are not aware of a charge that is not covered by your plan, you will be balanced billed after we obtain denial from your insurance carrier.

DELINQUENT ACCOUNTS

1. All delinquent accounts will be subject to a 1.5% monthly interest rate charge.
2. Accounts past due will be placed on a COD status at which time all charges must be paid in full until the account is brought current.
3. Accounts past due are subject to collection. All fees, including but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
4. There is a $30.00 service fee on all returned checks. Returned checks must be redeemed with certified funds (cashier's check, money order, credit card, or cash).

FOR MEDICARE PATIENTS

We are Medicare participating providers. We will bill Medicare and Medigap carriers. **You will be responsible at the time of service for payment of** annual deductibles, co-payments, charges for non covered or cosmetic services. If you have Medicare as well as a secondary coverage with a commercial plan that is an insurance company with which we have no contract, we will file a claim to your secondary/ supplemental carrier. If no payment is received from your secondary/ supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Your signature below signifies that you have received our financial policy and understand your responsibility regarding charges incurred in this office.

____

Signature of patient or legal guardian **Date**

____

Printed name of patient

Affiliated Dermatology®

IN-TAKE QUESTIONNAIRE

Patient Name: ______________________________ **Today's Date:** ____________

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: ______________________________

When did symptoms first occur? ______________________________

Frequency of symptoms? ______________________________

Describe the severity of the symptoms/pain. ______________________________

Are there any other symptoms associated with your problem? ______________________________

____

What makes the condition better and/or worse? ______________________________

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

☐ Acne
☐ AIDS
☐ Alopecia
☐ Arthritis
☐ Asthma
☐ Bladder Problems
☐ Blood Clots
☐ Cancer, Breast
☐ Bronchitis
☐ Cancer
☐ Chest Pain
☐ Chronic Cough
☐ Colon/bowel disease.
☐ Cough (Morning).
☐ Depression
☐ Diabetes
☐ Digestive Disorder
☐ Eczema
☐ Emphysema
☐ Fainting/Dizzy Spells
☐ Glaucoma
☐ Heart Murmur
☐ Hepatitis
☐ Herpes Simplex Virus (HSV)
☐ High Blood Pressure
☐ Blood Transfusion
☐ Heart Valve Replacement
☐ HIV
☐ Hives
☐ Hormone Deficiency
☐ Joint Replacement
☐ Keloid (raised scarring)
☐ Kidney Disease
☐ Low Blood Pressure
☐ Mitral Valve Replacement
☐ Heart Attack
☐ Pacemaker
☐ Phlebitis/Thrombosis
☐ Psoriasis
☐ Rheumatic Fever
☐ Rosacea
☐ Seasonal Allergies
☐ Seizures
☐ Skin Cancer – Basal Cell
☐ Skin Cancer – Melanoma
☐ Skin Cancer - Squamous Cell
☐ Stomach Ulcer
☐ Thyroid Ulcer
☐ Tuberculosis

☐ Other: ______________________________

ALLERGY HISTORY:

☐ **No Known Allergies** ☐ **NKDA (No Known Drug Allergies)**

☐ Acetaminophen
☐ Aspirin
☐ Codeine
☐ Epinephrine
☐ Erythromycin
☐ Ibuprofen
☐ Latex
☐ Lidocaine
☐ Metal
☐ Penicillin
☐ Sulfur
☐ Tetracycline

Other: ______________________________

MEDICATION HISTORY:

☐ I am not currently taking any medications ☐ No change since last visit

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	Name of Medication	Dosage

Name: ______________________ Date of Birth: ______________

PAST SURGICAL HISTORY:

List significant surgeries or injuries:

- ☐ Anesthetic Comlications (date: ________)
- ☐ Adenoidectomy (date: ________)
- ☐ Appendectomy (date: ________)
- ☐ Breast Augmentation (date: ________)
- ☐ Cataract Surgery (date: ________)
- ☐ Excision Surgery (date: ________)
- ☐ Gallbladder Surgery (date: ________)
- ☐ Heart Valve Replacement (date: ________)
- ☐ Hemangioma Excision (date: ________)
- ☐ Hernia Repair (date: ________)
- ☐ Hysterectomy (date: ________)
- ☐ Joint Replacement (date: ________)
- ☐ Laser Surgery (date: ________)
- ☐ Melanoma Excision (date: ________)
- ☐ Moh's Micrographic Surgery (date: ________)
- ☐ Organ Transplant (date: ________)
- ☐ Skin Graft (date: ________)
- ☐ Spinal Fusion – Lower Back (date: ________)
- ☐ Spinal Fusion – Neck (date: ________)
- ☐ Tonsillectomy (date: ________)
- ☐ No Pertinent Past Surgical History

Other Surgeries/Injuries	*Date(s) or Age*

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother	Daughter	Son
Acne Rosacea						
Alopecia						
Asthma						
Cancer, Basal Cell						
Cancer, Squamous						
Depression						
Diabetes						
Eczema						
Heart Disease						
High Blood Pressure						
Melanoma						
Psoriasis						
Thyroid Disease						

Other: ____

Name: ________________________________ **Date of Birth:** ______________

SOCIAL HISTORY:

Please describe your current tobacco use:

☐Smoker, current status unknown ☐Light tobacco smoker ☐Heavy tobacco smoker ☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoker ☐Unknown if ever smoked

Do you drink alcoholic beverages? ☐Yes ☐No If yes, please indicate how many servings per day: ______________

Have you ever used any illicit drugs? ☐Yes ☐No If yes, please indicate what type of drug and how often: __________

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Heavy ☐Vigorous

When you are exposed to sun without sunscreen do you: Tan Only / Burn and Tan / Burn ?

What is your eye color? ______________

Vitals:

Height:__________ Weight:__________

Women:

Are you pregnant? Yes / No If yes, what is your expected due date? __________________

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: ☐Normal
- ☐ Night Sweats
- ☐ Chills
- ☐ Dietary Changes
- ☐ Medication Changes
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Persistent Infections
- ☐ Fever

Skin: ☐Normal
- ☐ Bruising
- ☐ Change in Wart/Mole
- ☐ Dryness
- ☐ Excessive Sweating
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Nail Changes

Skin: (continued)
- ☐ New Lesions
- ☐ Pruritus
- ☐ Rash
- ☐ Skin Color Changes
- ☐ Ulcer
- ☐ Psoriasis

HEENT: ☐Normal
- ☐ Headache
- ☐ Blurred Vision
- ☐ Periorbital Puffiness
- ☐ Visual Disturbances
- ☐ Hearing Loss
- ☐ Deafness
- ☐ Epistaxis
- ☐ Seasonal Allergies
- ☐ Hoarseness

Neck: ☐Normal
- ☐ Neck Mass
- ☐ Swollen Glands

Respiratory: ☐Normal
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Wheezing

Name: ______________________________ Date of Birth: ____________________

(Review of Systems Continued)

Breast: ☐Normal
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Breast Swelling
- ☐ Skin Changes

Cardiovascular: ☐Normal
- ☐ Elevated Blood Pressure
- ☐ Fainting / Blacking Out
- ☐ Heart Stent
- ☐ Irregular Heartbeat
- ☐ Leg Cramps
- ☐ Leg Swelling
- ☐ Heart Murmur
- ☐ Shortness of Breath
- ☐ Pacemaker

Gastrointestinal: ☐Normal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Genitourinary: ☐Normal
(Female Only)
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Menstrual Irregularities
- ☐ Skin Rashes

Genitourinary: ☐Normal
(Male Only)
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Penile Lesions

Musculoskeletal: ☐Normal
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Swelling of Extremities

Neurological: ☐Normal
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of Consciousness
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke
- ☐ Tingling

Psychiatric: ☐Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Easily Irritated
- ☐ Hallucinations
- ☐ Memory Loss
- ☐ Mood Changes
- ☐ Nervousness
- ☐ Suicidal Thoughts
- ☐ Personality Changes

Endocrine/Glands: ☐Normal
- ☐ Appetite Changes
- ☐ Hair Changes
- ☐ Thyroid Problems

Hematology: ☐Normal
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Enlarged Lymph Nodes