Grosse Pointe Dermatology Associates, P.C.

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Name _____ Date of Birth:_____
Last First M.I.

Address:_____
Street City State Zip

Phone Number: _____ _____
Cell Phone Home Phone

May we leave a message if we receive your message center? YES or NO (if YES please indicate what number we may leave a message at) _____

Sex:_____ Marital Status: S_____ M_____ W_____ D_____

E-mail: _____@_____.com

Emergency Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

Responsible Party (if different from patient or patient is a minor)

Name: _____ Date of Birth: _____
Last First M.I.
Address (if different than patient: _____

Phone Number: _____ Relationship to Patient: _____

Name of Insurance Company: _____

Subscriber Date of Birth (if other than patient): _____ Relationship to Patient: _____

*****Please give you insurance card to the front desk so we may make a copy for our files.

Top 3 reasons for visit today, include duration of problem:
_____
_____
_____

Past Medical History. Please circle which apply to you.

Anxiety/ Arthritis/ Asthma/ Atrial Fibrillation (AFib)/ Bone Marrow Transplant/

BPH/ Breast Cancer/ Colon Cancer/ COPD Coronary Artery Disease Defibrillator/ Depression

Diabetes End Stage Renal Disease GERD Hearing Loss Hepatitis Hypertension

HIV/AIDS Hypercholesterolemia Hyperthyroidism Hypothyroidism Stroke

Leukemia Lung Cancer Lymphoma Prostate Cancer Radiation Treatment Seizures

Other :_____ NONE

Past Surgical History: _____

Skin Medical History: Please circle which apply to you.

Acne Actinic Keratoses Basal Cell Carcinoma Blistering Sunburns Dry Skin Eczema

Flaking or Itchy Scalp Hay fever/allergies Melanoma Poison Ivy Precancerous Moles

Psoriasis Squamous Cell Carcinoma NONE Other:_____

Do you use sunscreen? Yes No SPF used: 15 30 45 100

Do you use tanning booths? Yes No

Family History of Melanoma: Yes, if so which member _____ No

Medications: Please list medication names, strength and start date. NO MEDICATIONS

_____

_____

_____

_____

Allergies to medications, please list allergies and syndromes: NO ALLERGIES

_____

Smoking status: Never Former Current

Alcohol Intake: Never < 1 drink per day 1-2 drinks per day >3 per day

Do you have an advance directive? Yes or No

Driving Status: Drives in the Daytime Drive at Night

Family History of Heart Disease: Yes, if so which member _____ No

Family History of Non-Melanoma Skin Cancer: Yes, if so which member _____ No

Primary Care Providers Name: _____ Phone #: _____

Location _____ Last Visit to PCP:_____

Have you been vaccinated for pneumonia? Yes No

Have you been vaccinated for the flu this year? Yes No

Pharmacy Name:_____ Phone #: _____

Address_____ City/zip code:_____

Review of Systems: circle what applies to you- Problems with bleeding

Problems with healing/ Problems with scar/ Rash/ Seizures/ Pacemaker/

Immunosuppression/ Hay Fever/ Chest Pain/ Fever or Chills/ Night Sweats/

Unintentional Weight loss/ Thyroid Problems/ Sore Throat/ Blurry Vision/ Cough/

Abdominal Pain/ Bloody Stoll/ Bloody Urine/ Joint Aches/ Muscle Weakness/

Neck Stiffness/ Headaches/ Shortness of Breath/ Anxiety/ Depression/

Allergic to Adhesive/ Allergy to lidocaine/ Allergy to Topical Antibiotic Ointment/

Artificial Joints within past 2 years/ Artificial heart valve/ blood thinners/ MRSA/

Premedication prior to Procedures/ Rapid heartbeat with Epinephrine/

Pregnancy/ Planning on Pregnancy

Skin Concern Self-Assessment

Our practice is constantly striving to offer you the safest, most advanced procedures for skin rejuvenation and overall physical improvement. Which of the following health concerns would you like to address and/or learn more about? (Please check all that apply.)

- ☐ Frown lines between the brows
- ☐ Crows feet and forehead lines
- ☐ Significant lines around nose and mouth
- ☐ Fine lines and wrinkles
- ☐ Overall skin rejuvenation
- ☐ Hyperpigmentation
- ☐ Acne
- ☐ Large pore size
- ☐ Dry skin
- ☐ Rough skin texture
- ☐ Sun damage
- ☐ Facial redness or dilated blood vessels
- ☐ Other, please specify:

_____

- ☐ Dark circles under eyes/tear troughs
- ☐ Thin lips
- ☐ Sagging skin
- ☐ Restoring facial volume or fullness
- ☐ Loose and/or sagging earlobes
- ☐ Hand rejuvenation
- ☐ Excess facial and/or body hair
- ☐ Bluish or purple leg veins
- ☐ Excess body fat in the neck, abdomen, hips, flanks, back, arms, and/or thighs
- ☐ Excessive underarm perspiration
- ☐ Thin, sparse eyelashes

What products are in your current skincare regimen (face/body)? (cleanser, treatment, moisturizer, sunscreen)

_____

Please answer the following questions (circle answer):

When looking at my face in the mirror, I believe I look _____ than my true age.

Younger Than **Same Age** **Older Than**

When looking at my face in the mirror, I am _____ about the appearance of lines and wrinkles on my face.

Not Concerned **Somewhat Concerned** **Very Concerned**

When looking in the mirror, I am not _____ about the appearance of my body.

Not Concerned **Somewhat Concerned** **Very Concerned**

How did you hear about us?

_____ Friend or family member (name)

_____ Physician Referral or Insurance Company (name)

_____ Advertisement (please specify)

_____ Internet (website)

Patient Information

_____

Your name (please print) Address Phone number

We frequently have special offers which are **ONLY** distributed via e-mail. Would you like to be contacted for exclusive events and promotions?

___ Yes ___ No

_____@_____._____

E-mail address (please print)

NOTICE OF PRIVACY PRACTICES

Grosse Pointe Dermatology Associates, P.C.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient paperwork.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for service "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 3, 2013 and it is our intention to abide by the terms of this Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written, complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.
Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

I, _____, have read the above HIPAA information from Grosse Pointe Dermatology.

I give you permission to discuss my protected health information with:
(Please list the name(s) of the person(s) you will allow our office to discuss your protected health information with. If no names are given and a person calls on your behalf without being listed on this form, we will NOT provide them with any information about yourself, including upcoming appointment times. Please add as many personal names as you need, you do not need to add physicians in this section.)

_____ _____

Name & Relationship Name & Relationship

_____ _____

Please sign this line **Date**

I give Grosse Pointe Dermatology permission to contact my pharmacy for my prescription information:

_____

Pharmacy Name and phone number

_____ _____

Please sign this line **Date**