



PATIENT MEDICAL HISTORY

Last Name _____ First Name _____ M.I. _____ D.O.B. ____/____/____ Age _____

Primary Care Physician and Location: _____ Email: _____

Pharmacy (name, city, and street): _____

Whom can we thank for your referral?

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

Are you interested in any of the following services?

- Botox
- Filler
- Laser Hair Removal
- Skin Care Products
- Photo Rejuvenation
- Chemical Peels
- SculpSure
- 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): _____		

SOCIAL HISTORY	YES	NO
Do you smoke?		

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

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

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 anesthesia?		
Do you have liver or kidney disease?		
Do you have a bleeding or clotting disorder?		
Do you have a pacemaker or defibrillator?		

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

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

REVIEW OF SYSTEMS

For each question, check yes or no

CONSTITUTIONAL	YES	NO	MUSCULOSKELETAL	YES	NO
Fever or chills			Muscle weakness		
Weight loss			Neck stiffness		
Night sweats			Joint aches		
			PSYCHIATRIC		
Shortness of breath			Depression		
Cough			Anxiety		
Wheezing			NEUROLOGIC		
			Headache		
Abdominal pain			Seizures		
Bloody stool/urine			CARDIOVASCULAR		
			Chest pain		
Problems with bleeding			ALLERGIC/IMMUNOLOGIC		
			Immunosuppression		
Thyroid problems			Hay fever		
			EYES		
Sore throat			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.

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

Patient Signature: _____ DATE: _____

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)

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: _____

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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