RI DERMATOLOGY AND COSMETIC CENTER
PATIENT DEMOGRAPHIC
(Please Print Legibly)

Patient Name: _____DOB: _____ M F SS # _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Mailing Address: _____City: _____State: _____ Zip: _____

Preferred E-mail: _____Emergency Contact: _____

Emergency Contact Phone: _____ Relationship: _____

Married: _____ Single:_____ Widowed: _____ Divorced: _____ Legally Separated: _____

Primary Care Physician Name and Address:_____

Primary Ins. Co.: _____ Id #:_____ Group # _____

Secondary Ins.: _____ Id# _____ Group # _____

Subscriber Name and Address: _____

Subscriber DOB: _____ Relationship to Subscriber: _____

Have you met your deductible: Y N N/A Do you obtain a referral from PCP : Y N N/A

I authorize the release of medical information to my primary care physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I have received information regarding infection control measures and steps that are taken to prevent adverse events during surgery in this facility. This facility does not recognize any DNR Orders.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

I have presented a copy of the Notice of Privacy and information regarding the grievance process detailing how my health information may be used and disclosed as permitted under federal, state law, and outlining my rights regarding my health information.

I the undersigned/guardian have read the new patient brochure and understand the training, credentialing, and experience of all practitioners in the clinic. Rhode Island Dermatology reserves the right to charge $25.00 for any appointments missed or cancelled without 24 hour notice.

Patient or Responsible Party Signature _____ Date ___/___/___

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery	Hyperthyroidism
Arthritis	Disease	Hypothyroidism
Artificial joints	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal	Lymphoma
BPH	Disease	Pacemaker
Bone Marrow	GERD	Prostate Cancer
Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	Hypertension	Stroke
COPD	HIV/AIDS	Valve Replacement
	Hypercholesterolemia	NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement Knee (Right, Left, Bilateral)	
Joint Replacement Hip (Right, Left, Bilateral)	
Joint Replacement within last 2 years	Hysterectomy: Fibroids
	Hysterectomy: Uterine Cancer
	NONE

Other _____

Name and Location of Pharmacy: _____

Skin Disease History: (Please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratosis	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/Allergies	Basal Cell Skin Cancer
Blistering Sunburns	Melanoma	Poison Ivy
Dry Skin	Precancerous Moles	NONE

Other: _____

Do you wear Sunscreen? Yes No
If Yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: (Please list all medications and dosage)

_____
_____
_____
_____

Allergies: (Please list all allergies and reactions)

_____
_____
_____
_____

Social History: (Please circle all that apply)

Currently Smokes – Daily	Has never smoked
Currently Smokes – Not daily	Has smoked in the past
Drug Use	NONE

Other: _____

RHODE ISLAND DERMATOLOGY

Medical History: Review of Systems

Do you have or have you ever had problems with:

Allergy/Immunologic
☐ Yes ☐ No Premedication prior to procedure
☐ Yes ☐ No Allergy to Adhesive
☐ Yes ☐ No Allergy to Topical Antibiotic Ointments
☐ Yes ☐ No Allergy to Lidocaine
☐ Yes ☐ No Immunosupression
☐ Yes ☐ No Hay Fever

Integumentary/Skin
☐ Yes ☐ No Rash
☐ Yes ☐ No Changing Mole
☐ Yes ☐ No Problems with Healing
☐ Yes ☐ No Problems with Scarring (Keloid)

Hematology/Lymphatic
☐ Yes ☐ No Blood Thinners
☐ Yes ☐ No Problems with Bleeding

Endocrine
☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Pregnancy or Planning a Pregnancy

Respiratory
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Cough

Neurological
☐ Yes ☐ No Headaches
☐ Yes ☐ No Seizures

Eyes
☐ Yes ☐ No Blurry Vision

Cardiovascular
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Defibrillator
☐ Yes ☐ No Artificial Joints (past two years)
☐ Yes ☐ No Artificial Heart Valve
☐ Yes ☐ No Rapid Heart Beat with Epinephrine
☐ Yes ☐ No Chest Pain

Gastrointestinal (G.I.)
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Bloody Stool
☐ Yes ☐ No GI Upset with Antibiotics

Musculoskeletal
☐ Yes ☐ No Joint Aches
☐ Yes ☐ No Muscle Weakness
☐ Yes ☐ No Neck Stiffness

Psychiatric
☐ Yes ☐ No Depression
☐ Yes ☐ No Anxiety

Constitutional/Symptom
☐ Yes ☐ No Unintentional Weight Loss
☐ Yes ☐ No Fever or Chills
☐ Yes ☐ No Night Sweats
☐ Yes ☐ No Yeast Infections with antibiotics

Genitourinary
☐ Yes ☐ No Bloody Urine

ENT and Mouth
☐ Yes ☐ No Sore Throat

RHODE ISLAND DERMATOLOGY

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner (check all that apply):

___ Home Telephone # _____

___ OK to leave message with call-back number only

___ OK to leave a message with detailed health information

___ Work/Cell Telephone # _____

___ OK to leave message with call-back number only

___ OK to leave a message with detailed health information

VERBAL RELEASE OF INFORMATION

Rhode Island Dermatology is allowed to give verbal medical information or updates about your condition to your Power of Attorney or Healthcare/Legal Representative as listed in your medical record. If you wish others, such as relatives or friends, **who ask** about your condition, the right to be verbally informed about your condition when they ask, please list the names of those people on the lines below.

I am authorizing the release of verbal medical information regarding my treatment, care and updates on my condition to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- I understand that Rhode Island Dermatology will continue to rely on the information on this form when communicating with others involved in my care unless I request changes.
- I understand that I may revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing and the revocation will not apply to information that has already been disclosed prior to receipt of written revocation.

Patient/Guardian Signature: _____ Date: _____

Patient's Printed Name: _____ Date: _____

Rhode Island Dermatology & Cosmetic Center

3 Wake Robin Rd, Unit 5
Lincoln, RI 02865
Ph: 401-475-9140
Fax: 401-475-9143

This waiver is being used to ensure the integrity and purpose of the primary care physician referral system.

Patient Responsibility Agreement/ Referral Waiver

I, _____, am a member of _____ (HMO), and I have a scheduled appointment with Rhode Island Dermatology on ____/____/____.

I do not have a referral letter or authorized referral number. I understand that the referral letter or an authorized referral number is required prior to scheduling this visit in order to assure that it is a covered benefit. I acknowledge that I do not have a referral for today's visit but elect to receive care. This required referral letter and/ or authorizing is to be obtained and delivered to the provider's office within three business days of the date of service; it should also be backdated to the original date of service as noted above.

I also understand and agree that if I do not obtain the required letter and/ or authorization within three business days of the date of service and deliver it to the provider's office, then I will be responsible for the payment of charges and will be billed directly. The HMO will not be responsible for any charges connected with this visit.

Signature of Patient or Legal Guardian: _____
Date: ____/____/____

Signature of Witness: _____
Date: ____/____/____