BOONE DERMATOLOGY CLINIC
Nurse Intake Form
New Patient

Patient Name:_____ Today's Date:_____
Patient Date of Birth:_____

_____ List all medications below; or, _____ I give permission to BDC to obtain from my pharmacy.

1._____ 2._____ 3._____
4._____ 5._____ 6._____
7._____ 8._____ 9._____
10._____ 11._____ 12._____

Pharmacy: _____ **Location:** _____

FLU Vaccine Date: _____ **Pneumonia Vaccine Date:** _____

Shingles Vaccine Date: _____ **A1C Last Reading/Date:** _____

Allergies: (Please list all allergies to medications)

_____
_____
_____

Primary Care Provider: _____

Review of Systems: (Please circle all that apply)

Problems with bleeding
Problems with scarring
Allergy to adhesive
Allergy to lidocaine
Rapid heart rate with epinephrine
Allergy to topical antibiotics
Pacemaker / Defibrillator
Pregnant or planning a pregnancy
Fever or chills
Immunosuppression
Blood thinning medication

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smoke less than daily
- Smoke daily

Alcohol Consumption:
- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
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)? _____
Any other family history? _____

BOONE DERMATOLOGY CLINIC
Nurse Intake Form
New Patient

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes – Last A1C Read/Date _____
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (Please circle all that apply)

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

Boone Dermatology Clinic
Cancellation / No Show Policy

Thank you for trusting your dermatological care to Boone Dermatology. When you schedule an appointment with our practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, (and no later than 24 hours prior to your scheduled appointment). This will allow us to schedule other patients. Cancellations less than 24 hours and No shows disrupt the practice, and an unfilled slot is a lost chance to help another patient.

MOHS/Excision Cancellation and No Show Policy effective June 1, 2019:
Mohs / Excision Patients – Any patient who fails to show or cancels / reschedules and has not contacted our office **with at least 24 hours' notice and on a business day during our business hours:**

- First occurrence will be charged a $100 fee.
- Second occurrence will be charged a $250 fee.
- In the event of a third occurrence, you may be dismissed.

Office Visit No Show Policy effective June 15, 2018:

- Any established patient who fails to show for their first appointment will be considered a No Show and will be mailed a reminder notice.
- Any established patient who fails to show for their second visit will be charged $50.00.
- Any established patient who fails to show three times may be dismissed from the practice.

Cancellation and No Show fees are charged to the patient, not the insurance company, and are due prior to scheduling the patient's next office visit. As a courtesy, 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 office during regular business hours, Monday through Friday.

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

_____ _____
Signature of Patient, Parent/Legal Guardian Relationship to Patient

_____ _____
Printed Name Date

BOONE DERMATOLOGY CLINIC, P.A.

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, _____, of _____ County, State of _____,

am the custodial parent having legal custody of _____, a minor child, age _____, born on _____

_____, in _____ County, State of _____, give my permission to provide services which may be medically necessary or proper to provide for the health care of the minor child, including, but not limited to, the power to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing. By signing here, I indicate that I have the understanding and capacity to recognize the importance of, to communicate, and to assign the health care decisions covered by this document, I am fully informed as to the contents of the document, and I understand the full scope and importance of this grant of powers to the agent named herein.

_____ _____

Custodial Parent's Signature Date

_____ _____

Witness Date

_____ _____

Witness Date

(8/2019)

BOONE DERMATOLOGY CLINIC
169 BIRCH STREET, BOONE, NC 28607
CONSENT FOR USE OR DISCLOSURE OF INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS (HIPAA)

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Boone Dermatology Clinic, in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Boone Dermatology Clinic's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form.

Boone Dermatology Clinic reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Boone Dermatology Clinic does change the terms of its Notice of Privacy Practices, you may obtain a copy upon request to the Front Office Staff.

I retain the right to request that Boone Dermatology Clinic further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Boone Dermatology Clinic is not required to agree to such requested restrictions, however, if Boone Dermatology Clinic does agree to my requested restriction(s), such restrictions are then binding on Boone Dermatology Clinic.

PHONE CONSENT: I authorize the physicians and staff of Boone Dermatology Clinic to:

- Call me as early as 7 A.M.? _____ Yes _____ No If no, please designate earliest available time: _____
- Leave a message on my answering machine or voice mail at home? ___Yes ___No Ph #:_____
- Leave a message on my cell phone? ___Yes ___No Ph #:_____
- Text message my cell phone? ___Yes ___No Ph #:_____
- Leave a message at my place of employment? ___Yes ___No Ph #:_____

EMAIL CONSENT: I authorize Boone Dermatology Clinic to email information to me at my email address: _____ _____ rather than the US Postal Service.

DESIGNATED INDIVIDUALS AUTHORIZATION:
I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM PCP AND PRESCRIPTION VERIFICATION:
I hereby authorize Boone Dermatology Clinic to request and receive release of any protected health information regarding my treatment by my Primary Care Provider and my prescription verification by Surescripts.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Boone Dermatology Clinic in writing to the address above. The revocation shall be effective except to the extent that Boone Dermatology Clinic has already taken action in reliance on the content. Boone Dermatology Clinic may refuse to treat you if you do not sign this Consent Form or provide further treatment to you at the time of revocation (except to the extent that Boone Dermatology Clinic is required by law to treat individuals).

I have read and understand this information. I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

_____ _____
SIGNATURE OF PATIENT DATE OF BIRTH

_____ _____
PLEASE PRINT NAME TODAY'S DATE

_____ _____
SIGNING ON BEHALF OF PATIENT PLEASE PRINT NAME

_____
RELATIONSHIP TO PATIENT

Boone Dermatology Clinic

169 Birch Street, Boone NC 28607

Patient Guarantor (Responsible Party) Form

Authorization to Treat / Payment Responsibility

Please complete the following information:

Last Name _____ First Name _____ MI _____

Maiden/Alt Name _____

Address _____

City _____ State _____ Zip _____ **Email Address** _____

Home Ph (____)_____ Referring Physician _____

Date of Birth _____/_____/_____ Age _____ Employer Name/Ph#_____

Marital Status _____ Sex _____ Work Ph (____) _____ Ext. _____ Cell Ph (____)_____

Emergency Contact _____ Relation _____ Phone (____)_____

Race _____ Ethnicity _____ Language _____ Decline to Answer _____

Student Yes ___ No ___ Full-Time ___ Part-Time ___ Name of School _____

Insured (Policyholder) Information – Primary Carrier: (Please present your insurance card at check-in)

Ins Co Name _____ Policy # _____

Address 1 _____ Group # _____

Address 2/City St Zip _____

Patient Relation to Insured: Self ___ Spouse ___ Child ___ Other ___

Policy Holder Name/Address 1 _____

Address 2/City St Zip _____

Phone (____)_____ Date of Birth _____/_____/_____ Sex _____

Employer Name/Phone #_____

Insured (Policyholder) Information – Secondary Carrier: (Please present your insurance card at check-in)

Ins Co Name _____ Policy # _____

Address 1 _____ Group # _____

Address 2/City St Zip _____

Patient Relation to Insured: Self ___ Spouse ___ Child ___ Other ___

Policy Holder Name/Address 1 _____

Address 2/City St Zip _____

Phone (_____)_____ Date of Birth _____/_____/_____ Sex _____

Employer Name/Phone # _____

I give authority to Boone Dermatology Clinic to treat my skin condition. I am aware of Boone Dermatology Clinic's Privacy Policy, and that I may receive a copy upon request.

It is the patient's responsibility to know their insurance coverage benefits, obtain any necessary referrals, and to notify our office of any changes to your insurance coverage. I agree that I will be responsible for any services not covered by my insurance or any remaining balance, regardless of insurance status. I understand that co-pays are due at the time of service.

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to BOONE DERMATOLOGY CLINIC, P.A. I understand payment is due at time of service.

Signature of Responsible Party _____ Date _____

(3/2019)