



**DERMATOLOGY MEDICAL HISTORY**

Patient # \_\_\_\_\_

Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for visit today: \_\_\_\_\_

How did you hear of us? [ ] Newspaper [ ] Telephone Book [ ] Friend (name: \_\_\_\_\_) [ ] other \_\_\_\_\_

Are you allergic to any medications? [ ] Yes [ ] No If yes list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever had dental anesthesia (Novocain)? [ ] Yes [ ] No Any bad reaction? [ ] Yes [ ] No

List all medications you are currently taking including prescriptions, over the counter medications, vitamins, and/or herbals:

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (please check YES or NO)

<b><u>LUNGS:</u></b>	<b>YES</b>	<b>NO</b>	<b><u>OTHER SYSTEMIC:</u></b>	<b>YES</b>	<b>NO</b>
Bronchitis	[ ]	[ ]	Diabetes	[ ]	[ ]
Emphysema	[ ]	[ ]	Excessive thirst/hunger	[ ]	[ ]
Asthma	[ ]	[ ]	Thyroid	[ ]	[ ]
Chronic Cough	[ ]	[ ]	Kidney	[ ]	[ ]
Morning Cough	[ ]	[ ]	Bladder	[ ]	[ ]
Shortness of Breath	[ ]	[ ]	Frequency/burning	[ ]	[ ]
Wheezing	[ ]	[ ]	Gastro Intestinal Stomach Absorptive Disorder	[ ]	[ ]
<b><u>CARDIOVASCULAR:</u></b>	<b>YES</b>	<b>NO</b>	Nausea, vomiting, diarrhea When taking antibiotics	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Yeast infection when taking antibiotics	[ ]	[ ]
Chest Pain	[ ]	[ ]	Arthritis/Joint Deformity	[ ]	[ ]
Heart Attack	[ ]	[ ]	Arthralgia	[ ]	[ ]
Heart Murmur	[ ]	[ ]	Limited Motion	[ ]	[ ]
Irregular Heartbeat	[ ]	[ ]	Artificial joint	[ ]	[ ]
Phlebitis	[ ]	[ ]	Convulsions, Epilepsy or Seizures	[ ]	[ ]
Inflammation of vein	[ ]	[ ]	Fainting	[ ]	[ ]
Blood clots	[ ]	[ ]			
Pacemaker	[ ]	[ ]			
Artificial Valve/s	[ ]	[ ]			

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

**Skin:**

Have you ever had Melanoma? [ ] Yes [ ] No If yes, when and what body part? \_\_\_\_\_

Has any blood relative ever had Melanoma? [ ] Yes [ ] No If yes, when and what body part? \_\_\_\_\_

Have you ever had skin cancer? [ ] Yes [ ] No If yes, what kind and where? \_\_\_\_\_

Has anyone in your family had skin cancer? [ ] Yes [ ] No

Do you have a history of any specific skin diseases? [ ] Yes [ ] No If yes, what? \_\_\_\_\_

Do you bleed easily? [ ] Yes [ ] No

Do you develop skin rashes in reaction to: [ ] Medications? [ ] Food? [ ] Environment? \_\_\_\_\_

**Social History:**

Do you drink alcohol? [ ] Yes [ ] No If yes, number of drinks per day \_\_\_\_\_

Do you use IV drugs? [ ] Yes [ ] No If yes, what? \_\_\_\_\_ how often? \_\_\_\_\_

Do you smoke? [ ] Yes [ ] No If yes, how much: \_\_\_\_\_

Have you had or have you been exposed to HIV (AIDS)? [ ] Yes [ ] No

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

(Women) Are you pregnant? [ ] Yes [ ] No If yes, Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Completed by: [ ] Patient: Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

[ ] Medical Assistant, Initials: \_\_\_\_\_ Reviewed by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# FINANCIAL POLICY AND DISCLOSURE

Please Sign and Date

The Financial Policy and Disclosure is to help Coastal Dermatology/Michele A. Mittelbronn, M.D. provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

## **Self-Pay Policy:**

- If you are a self-pay patient, you will be required to pay your balance in full at the time of service.
- If you are unable to pay the balance at the time of service, a financial agreement may be established and must be agreed upon prior to provision of services.

## **Insurance Policy:**

- If you are an insurance patient, we require the coverage to be verified for each patient at least once per calendar month. If the coverage cannot be verified, we require you to leave credit card information so that once the coverage is verified we may process the patient responsibility portion to your credit card.
- It is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within thirty (30) business days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected at the time of service.
- In special cases, we may need your help in contacting your insurance company for the payment of your services and therefore you must agree to fully cooperate in assisting us should that be necessary.

## **Cancelation / No-Show:**

- We require 24 hours notice to cancel your appointment.
- Patient's who miss their regular scheduled or surgical appointment and do not give adequate notice of a cancellation, will be charged a \$25.00 cancellation/no-show fee.
- Payment of any outstanding no-show fees will be required to schedule another office visit.

TO HELP IN THIS POLICY WE ASK THAT YOU ASSIST US BY:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, co-pay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check-out associate, front desk administrator &/or billing director.

---

Responsible Party's Signature

---

Date

NOTICE OF PRIVACY PRACTICES  
OF  
COASTAL DERMATOLOGY, LLC  
APRIL 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT.**

All patients have the right to know that their Personal Health Information (PHI) remains confidential. The Privacy Rights and Practices of Coastal Dermatology were established to protect the healthcare information of our patients as required by Section 164.520 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These guidelines restrict the release of your medical information for the purpose of treatment, payment, and healthcare operations. The following are examples of agencies or facilities to which your personal health information may be released in the course of your treatment:

- Health Insurance Providers
- Pharmacies
- Laboratory Testing Facilities
- Hospitals
- Physician Consults
- Surgical Facilities
- Physical Therapies
- Physician Intern Training

Other uses or disclosures permitted or required by law:

- Public Health Activities
- Health Inspection Agencies
- Law Enforcement Purposes
- Workers' Compensation
- Specialized Government Functions (Military or Veterans' Activities)
- Reporting Abuse, Neglect, or Domestic Violence
- Judicial Proceedings
- Disclosures about Decedents (Coroner/Funeral Director)
- Avert Serious Threat to Public Health or Safety

**THE RELEASE OF HEALTHCARE INFORMATION TO ANY OTHER SOURCE IS PROHIBITED WITHOUT THE WRITTEN AUTHORIZATION OF THE PATIENT OR GAURDIAN.**

As a patient or guardian, you have the right to:

- Request restrictions on certain uses and disclosures of your health care information;
- Inspect and request changes to your medical records;
- Obtain a copy of your medical record (Fee charged for copies);
- Find out what disclosures of your record have been made;
- Receive confidential communications;
- Ask questions about the Privacy Policy; and
- File a complaint with Coastal Dermatology, LLC or the Secretary of Health and Human Services without the fear of any reprisals, if you believe your privacy rights have been violated.

Coastal Dermatology, LLC is required by law to abide by the terms outlined in this notice. However, Coastal Dermatology, LLC reserves the right to change the terms of this Privacy Notice and made the new provisions effective for all protected health information that we maintain. Any revisions of this notice will be posted and distributed during office appointments.

If you need help reading or understanding this form, please tell the Receptionist.

Patient Name: \_\_\_\_\_ Chart # \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**COPY AVAILABLE UPON REQUEST**