# ACKNOWLEDGEMENT OF POLICIES & CONSENT FOR TREATMENT

## AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION

There will be times when we may need to contact you, such as with pathology or laboratory results when applicable. Please make sure you have checked the boxes on Page 1 to let us know which ways are okay for us to contact you.

**Is it OK for us to leave a detailed voicemail with results?** **□Yes** **□No**

□ Please contact ONLY ME with results

□ I hereby authorize and give permission to Legacy Dermatology, PLLC, the offices of Jennifer Dharamsi, MD, to disclose and discuss any information related to my medical condition with the following persons:

**Name** ______________________________**Relationship** _________________________**Phone**_____________________

*I understand that requests for medical information from persons not listed above will require a specific signed authorization prior to the disclosure of any medical information. The duration of this authorization is indefinite unless I revoke it in writing.*

**Signature**__X_____________________________________________________**Date**_______________________________

## ACKNOWLEDGEMENT OF POLICIES

*Please kindly review the "Policies" section of the folder provided to you today labeled "Legacy Dermatology Policies & General Medical Consent". Note that these forms are also available online and can be printed for you to take home at your request. I acknowledge that I have read, understand and fully agree with the policy information presented to m, as listed below.* ***I specifically acknowledge the no show and cancelation policy and fees associated with said policy. I acknowledge my understanding that all product sales are final. Please see "Our Financial Policy" for more details.***

- Our Office Policy
- Our Financial Policy
- Non-Discrimination Policy
- Notice of Privacy Practices

**Signature**__X_____________________________________________________**Date**_______________________________

## GENERAL MEDICAL CONSENT

*Please kindly review the "Consent" section of the folder provided to you today labeled "Legacy Dermatology Policies & General Medical Consent". Note that this consent form can be printed for you to take home at your request. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatments. I acknowledge that I have read, understand and fully consent to the treatments discussed in detail within this consent form.*

**Signature**__X_____________________________________________________**Date**_______________________________

# New Patient Medical Questionnaire

**Name** ________________________________________**Today's Date**____________ **DOB**____________________

**How did you hear about our practice?**

- □ Insurance Company
- □ Primary Care Provider (Who?): ____________________________________________________
- □ Web Search / Social Media
- □ Print Ad (Which publication?): ____________________________________________________
- □ Friend or Family Member
- □ Other: ______________________________________________________________________

**Reason for today's visit:** ______________________________________________________________________

**Have you ever been seen before by any of our dermatology providers (Jennifer Dharamsi, MD, Brad Armstrong, PA, and/or Patrice Simon, PA):** □Yes □No

If so, when and where was your most recent visit? _________________ What was the reason for your last visit? ____________

If not, who is your current dermatologist? ____________________________________________________________________

When was your last skin check, if ever? ______________________________________________________________________

**What is your Past History of Skin Problems, if any?** ___________________________________________________________

______________________________________________________________________________________________

**Have you ever been diagnosed with skin cancer?** □Yes □No

**Have you ever been diagnosed with an atypical mole/dysplastic nevus?** □Yes □No

If yes, please list the type of skin cancer (basal cell carcinoma, squamous cell carcinoma, or melanoma) and date of treatment, to your best recollection:__________________________________________________________________________________________

**Have you ever had any of the following conditions? Please check all that apply:**

- □ Allergy to adhesive
- □ Allergy to lidocaine
- □ Allergy to topical antibiotics
- □ Artificial Heart Valve
- □ Artificial Joint Replacement
- □ Pacemaker / Defibrillator
- □ Taking blood thinners
- □ Rapid heartbeat with epinephrine
- □ Require antibiotics before surgery
- □ MRSA
- □ AIDS/HIV
- □ Anemia
- □ Arthritis
- □ Autoimmune disease
- □ Asthma
- □ Blood disease/Easy bruising
- □ Chemotherapy (active)
- □ Cold sores/Fever blisters
- □ Diabetes
- □ Dizzy spells/fainting
- □ Epilepsy/Seizures
- □ Eye Problems
- □ Fibromyalgia
- □ Hay fever/Seasonal allergies
- □ Heart disease
- □ Hepatitis
- □ Herpes
- □ High blood pressure
- □ Keloid scarring
- □ Kidney Disease
- □ Liver disease
- □ Lupus
- □ Melanoma
- □ Mental/Nervous Disorder
- □ Phlebitis/Vein inflammation
- □ Radiation Treatment
- □ Respiratory/Breathing Problems
- □ Sinus Problems
- □ Stroke
- □ Tuberculosis
- □ Ulcers
- □ Varicose veins
- □ Venereal Disease/ST

**Do you have a family history of <u>melanoma</u>?** □Yes □No **If so, what relative?**___________________________________

**Please list any and all current prescription medicines and supplements that you take, including any topical medications:**

_____________________________________________________________________________________________

**Do you have any allergies to latex, medications, herbals/supplements, or skin contactants?** □Yes □No

**If yes, please list:**_____________________________________________________________________________________

**Do you smoke?** □ Never | □ Yes, <u>currently</u> (how many packs/day?)___ | □ Not now, but in the past (when quit?)___________

**Do you use tanning beds?** □Never | □Yes, currently (how often?)_____ □Not now, but in the past (how long/often?)_________

**Do you use sunscreen?** □Never | □Rarely | □Only with prolonged sun exposure | □Most days | □Every day | SPF?__________

**<u>WOMEN</u>**: Are you pregnant? _______If yes, Due Date_______ If not, are you currently trying to conceive?________________

Are you currently breastfeeding?___________________________Are your menstrual cycles normal?_____________________