Nikko
DERMATOLOGY

Patient Information Forms

Please legibly print the following information on the front and back in black ink

Patient Name: ____
Last First Middle

Home Address: ____
Street & Apt. City State Zip

Home Phone:_____________________**Cell:**________________________**Work:** ____________________

Date of Birth:_________________**Gender:**________ **E-mail:** __________________________________

Marital Status: Single______ **Married (Spouse's Name):** ___________________________________

Emergency Contact: ___________________________________**Relationship:** ___________________
(Name)

Contact Phone:______________________________**Alternate Phone:** ____________________________

I will be using insurance for my dermatology appointment: ______NO ______YES

Referral Source (check all that apply):

______Social Media ______Website / Web Search ______Magazine ______Word of Mouth

______TV Commercial ______Yellow Pages ______Radio ______Other

Patient that we can thank for referring you (Name): ____

Cancellation and No Show Policy

Effective 6/8/18

In order to provide the highest quality of care to our patients, we have established a formal, "Cancellation & No Show Policy." This is intended to increased physician and staff productivity, to improve timely access to all patients and to reduce/eliminate empty slots in the appointment schedule.

We understand there may be circumstances that require you to cancel an appointment; however, we require that you notify our office at least 48 hours in advance to avoid charges.

In the event you are unable to make it to your appointment and either cancel or no show within the 48, you will lose your deposit/consult fee and will be charged accordingly for a future appointment.

Patient Signature **Date**

(*If Patient is a minor, legal representative must sign consent)

Nikko Dermatology

Authorization for and release of photographs and videos

I authorize Anthony Nikko, M.D. and his associates the right to use photographs and videos of myself for my professional medical purposes deemed appropriate, including, medical purposes related to the case, before and after photographs for Dermatology patients to view in the office, Nikko dermatology and Cosmetic Surgery Center website and all outlets of Social Media. I understand my name and face will kept private and confidential, unless I authorize otherwise through writing.

I understand Dr. Anthony Nikko M.D. is not obligated to make use of the rights to set forth herein. I also understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

____

Patient Signature **Date**

(*If Patient is a minor, legal representative must sign consent)

Please check "Yes" or "No" for the following questions:

Are you **ALLERGIC** to any medications? (List below) _______NO _______YES

____

____

Have you ever been diagnosed with **Hepatitis**? _______NO _______YES
If so, CIRCLE which: Hepatitis A B C

Do you have or have you been exposed to the **HIV virus**? _______NO _______YES

Do you have a problem with **excessive sweating**? _______NO _______YES

Please list the cosmetic procedures, skin care and/or dermatology treatments you are interested in:

____

____

First day of last period:___________________________**Number of Pregnancies:** __________________

What pharmacy would you like to add for prescriptions?

Pharmacy Name: ____

Pharmacy Address: ____

Phone Number: ____

I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I fully understand that I am financially responsible for ALL medical services provided to me at the time of service.

____

Patient Signature **Date**
(*If Patient is a minor, legal representative must sign consent)

HIPPA Privacy Rule

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request that communications be made in a confidential manner.

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

□ * HOME Telephone Number: ___________________________________

- □ O.K. to leave message with detailed information (e.g., appointment reminders)
- □ Leave message with call-back number ONLY

□ * CELLULAR Telephone Number: ___________________________________

- □ O.K. to leave voice/text message with detailed information (e.g., appointment reminders)
- □ Leave voice/text message with call-back number ONLY

□ * WORK Telephone Number: ___________________________________

- □ O.K. to leave message with detailed information (e.g., appointment reminders)
- □ Leave message with call-back number ONLY

*(Please check at least one) at the above number(s), you authorize our office to speak with:

- □ Emergency contact listed
- □ Patient only
- □ Patient and/or other authorized person(s)

Please list name(s) below:

____

____

____

____

Patient Signature **Date**

(*If Patient is a minor, legal representative must sign consent)

Nikko

DERMATOLOGY

NAME:____ **DATE:**____/____/______

DATE OF BIRTH: ___/___/____ Name I prefer to be called: ____________________

PAST MEDICAL HISTORY (Please **circle** all that apply)

Anxiety
Depression
Arthritis
Artificial Joints
Diabetes
None of the Above
End Stage Renal Disease
Hearing Loss
Heart Attack/Stroke
Hepatitis B or C
HIV/AIDS
Leukemia or Lymphoma
Radiation Treatment
Pacemaker
Cancer:___________________________
Other:____________________________

PAST SKIN DISEASE HISTORY (Please **circle** all that apply)

Acne
Actinic Keratoses
Pancreatic Mole
Eczema
Basal Cell Carcinoma
None of the Above
Dry Skin
Melanoma
Asthma
Flaking or Itchy Scalp
Squamous Cell Carcinoma
Other____
Poison Ivy
Vitiligo
Hayfever/Allergies
Psoriasis
Melanoma

PAST SURGICAL HISTORY (Please **circle** all that apply)

Heart Valve Replacement
Squamous Cell Carcinoma Surgery
Masectomy
Other: _________________________
Skin Biopsy
Basal Cell Carcinoma Surgery
Joint Replacement ______________
None of the above
Melanoma Surgery
Lumpectomy
Cosmetic surgery

Do you wear Sunscreen? Yes No
If Yes, what SPF?_____________ how often? daily sometime only at the beach

FAMILY HISTORY (Please circle all that apply)

- ◻ Do you have an immediate family history of melanoma? **Yes** or **No**. If yes (Mother Father Sister Brother or Child)
- ◻ Are there any pertinent or major skin problems that run in your family?____

SOCIAL HISTORY:

- ◻ Currently Smokes? Yes or No, if yes- how many____Cigarette a day, for how many year?_____________________
- ◻ Alcohol? Yes or No, if yes, how many drinks daily?____
- ◻ Are you on any kind of diet? Yes or No**,** If yes what diet?____
- ◻ What is your current and/or former occupation? ____
- ◻ What type of outdoor activities, if any, do you participate in? ____
- ◻ Do you have any other hobbies or activities you would like us to know about? _____________________________
- ◻ Do you have any children or pets? ____
- ◻ With whom, if anyone, do you live? ____
- ◻ Where do you live (generally speaking: what town or city or county, assisted living facility)?____________________
____
- ◻ Are you currently using any dermatology lotion for skin care? Yes or No, if yes what product?___________________
- ◻ Are you interested in cosmetic surgery? Yes or No____

MEDICATIONS (Please List any medications, including vitamins and supplements, doses & frequencies, tablet or liquid)

Medications	Doses	Directions

ALLERGIES TOP MEDICATIONS (Please list any medication allergies and the **type of reaction** that occurred)

____

PHARMACY (Please provide the pharmacy name, phone#, and address)

____

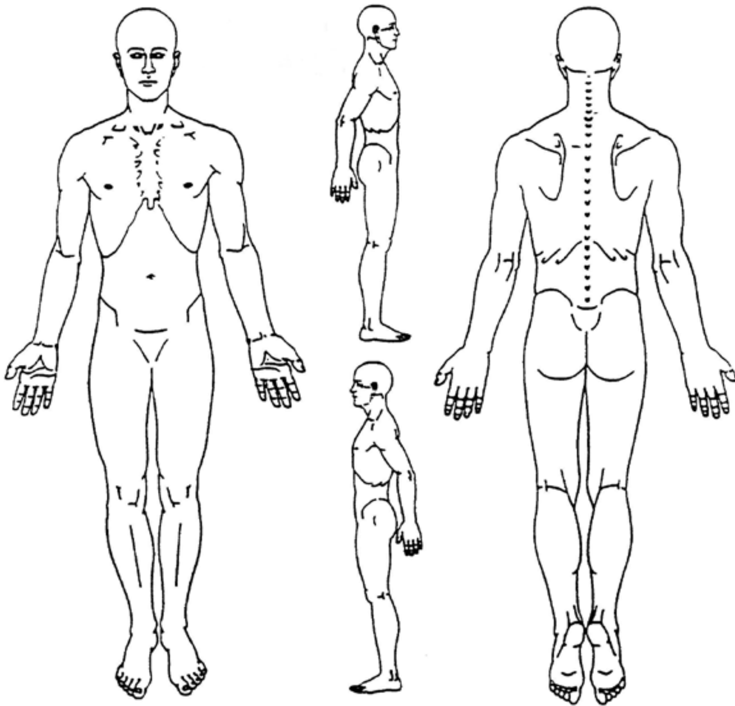
PRIMARY CARE DOCTOR: ______________________**REFERRING DOCTOR:**___________________________

DERMATOLOGY ALERTS (Please **circle** any of these important alerts if they apply to you)

Allergy to topical antibiotic
Rapid heartbeat with epinephrine
Allergy to adhesive
Allergy to Lidocaine
Artificial heart valve
Artificial joints within last 2 years
Premedication prior to procedures
Blood thinners
Defrillator
Pacemaker
Pregnant, planning or nursing
Other:___________________

PLEASE DETAIL THE REASON FOR TODAY'S VISIT

Location: (Mark Site on chart below)



Problem: ____________________________________

____

Quality: Symptomatic

Itch bleed tender scaly rough darker enlarging

Severity: **mild** **moderate** **severe**

____

Duration: How Long? _________________________

____

Previous Treatments: (Lotions, OTC, Prescription or other?)

____

What makes it better or worse? _________________

____

____

Nikko

DERMATOLOGY

Do you have any other rashes? YES or NO
Do you have any problems with allergy or your immune system? YES or NO
Do you have any stress? YES or NO, If yes, how significant?____
Do you have problems with scarring? YES or NO
Do you have problems with bleeding? YES or NO