Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____

Emergency Contact: _____ Phone Number: _____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Intake and History Form

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____
_____
_____

Intake and History Form

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have 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

Have you tan in the past?

◯ Yes ◯ No

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____

_____

Intake and History Form

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Intake and History Form

Occupation and Workplace:

_____

_____

Place of Residence:

_____

_____

Family History

Please include only first-degree relatives:

_____

_____

_____

Review of Systems

Please check yes or no for the following:

Symptom	Yes	No

Alerts

Please check yes or no for the following:

Symptom	Yes	No

Consent to Treat

I have the legal right to consent to medical and surgical treatment because (a) I am the patient, or (b) I am the parent/representative/guardian of the patient.

I voluntarily authorize and consent to medical care, treatment, and diagnostic test that the providers at TruDerm and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this for, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long a physician/patient relationship exists or until I withdraw my consent.

Patient / Agent / Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

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

When you receive treatment or benefits from True Dermatology, we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your information without your authorization for treatment, payment and health care operations purposes. Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performances, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use and disclose your health information without your authorization to contact you for the following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following purposes:

- For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issue to the FDA;
- To comply with workers compensation laws and similar programs;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency reasonably believes you are a victim of abuse, neglect, or domestic violence we will make every effort to obtain your permission, however, in some cases we may be required or authorized to alert the authorities;
- For health oversite activities such as audits, investigations, and inspections of DSHS facilities;
- For research approved by a privacy Board; for preparing for research such as writing a research proposal; or for research on decedents information;
- To create or share de-identified or partially de-identified health information (limited data sets);

- For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
- For law enforcement purposes such as identifying or locating a suspect or missing person;
- To coroners, medical examiners, or funeral directors as needed for their jobs;
- To organizations that handle organ, eye or tissue donation, procurement, or transplantation;
- To avert a serious threat to health or public safety;
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable step to keep information confidential; and
- As otherwise required or permitted by local, state or federal law.

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized bylaw. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may cancel your authorization by writing to the privacy officer per below.

YOUR PRIVACY RIGHTS

Although your health record is property of True Dermatology, you have the right to:

- Inspect and copy your health information, including lab reports, upon written request and subject to some exceptions. We may charge you a reasonable cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request an accounting (a list) of certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.
- Request that we restrict how we use and disclose your health information for treatment, payment and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we do not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to the front desk of the True Dermatology office. You can reach us by telephone at 972-635-3400 or by email from our website at https://truderm.com.

OUR DUTIES

We required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy information that identifies you and notify you in the

event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the rights to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post revised notices on our website at https://truderm.com and in waiting room areas. You may request a copy of the revised notice at the time of your next appointment.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by contacting our Office Manager. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue. S.W. Washington, DC or by calling (202) 619-257, or the Office for Civil Right, U.S. Department of Health & Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202, 1-800-368-1019; 1-800-537-7697 (TDD). It is your right to file a complaint if needed and there will be no retaliation for such a filing.

_____

Patient / Agent / Guardian Signature Date

Financial Responsibility

I accept full financial responsibility for all items and services furnished by TruDerm. In the event I am entitled to benefits of any type arising out of any policy of insurance insuring me or any other party liable to me, those benefits are hereby assigned to TruDerm for application against my bill. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or not covered by the assignment.

I have read this form, or this form has been read to me in a language that I understand, and I have had the opportunity to ask questions about it.

Patient / Agent / Guardian Signature Date

TruDerm-Allen 918 Watters Creek Blvd, Allen,Texas 75013|Phone: (972) 635-3400|Fax: (866) 242-0765

TruDerm
Dermatology for Healthy and Beautiful Skin

Missed Appointment / Cancellation policy:

24-Hour Notification Required

In our practice we recognize that your time is valuable, and we make every effort to ensure that we are considerate of this time and provide the best service possible. For us to maintain this level of service, we ask our patients to give us a 24-hour notice if they are unable keep their appointment. This allows opportunity to serve other patients in need of care.

1. ***Cancellation/ No Show Policy for Doctor Appointment***
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

2. ***Account balances***
   We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

I acknowledge that I have read and understand TruDerm's missed appointment policy.

_____
Print Name

_____ _____
Patient / Authorized Signature Date