Dermatology-Dermatologic Surgery- Aesthetic and Cosmetic Dermatology

Legal Name: ______________________ Preferred Name: ______________________

Sex: M/F_______ DOB: ______________ SSN#: ______________ Marital Status: ______________

Street Adress:____

City / State: ______________________________Zip Code: ______________

Cell Phone Number: ______________________Home Number: ______________________

Best way to contact **(Circle One):** Cell / Home / Email Would you like to receive emails? YES / No (**Circle One**)

Email Address:______________________@______________________

Preferred Language: ______________ Race: __________ **Ethnic Group:**______________________

Primary Care Physician: ______________________Referred By: SELF or Other: ______________________

Preferred Pharmacy: ____

INSURANCE COMPANY: ______________________RELATION TO INSURED: ______________________

Although we accept Aetna, BlueCross BlueShield (not Blue Lincs), First Health, Health Choice, Humana, and Medicare, you are expected to pay a yearly unmet deductible or co-pay at each visit. Aetna-HMO & Humana-HMO require your primary doctor's referral dated on or before your visit. Insurance companies return explanations of benefits and payments to you 5-7 days before we get them. We are not in network with Cigna or UnitedHealthcare. They will still cover our allowed charges subject to you meeting your deductible.

For products or procedures, a separate payment is often due at the time of your visit. These charges are subject to your annual surgical deductible and are due prior to your visit. Please advise receptionist before your visit if you arrive without the ability to pay. We will be happy to reschedule you.

Medicare patients: your annual deductible of $233 is due at your first visit of the year, whether or not your secondary insurance paid it last year. This is because policies for many of them have changed. Items **usually not** covered by insurance: fillers, hair loss, skin tags, warts (unless bleeding), skin products, and cysts (unless painful).

Prescriptions are refilled only if you have been seen within the past 90 days and the account is up to date. **A $40 service fee is charged for:** returned checks. **The fees may be added to your account.**

I understand and accept the above office policies. I am responsible for the payment of all professional and administrative fees incurred by myself or my dependents at this office regardless of insurance that I may have. I give permission for Dr. Graham and his associates to treat me or my minor child. I authorize my insurance benefits to be paid directly to Graham Dermatology Center or Silver Leaf Dermatology. I authorize Graham Dermatology Center or David Graham, M.D. to release any information to my insurance company upon my written request, and to charge my credit card for any unmet deductibles that are due, either upon receipt of advice from my insurance company, or phone requests from us. This avoids a billing fee.

For questions with any of the above, please ask our staff for assistance prior to visit. To put your payment or unmet deductible on Care Credit®, please notify the receptionist or office coordinator.

Signature: ______________________________ Date:______________________

Intake and History Form

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Elevated blood pressure
- ☐ End-stage Renal Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ Hearing Loss
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis (liver inflamed)
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of prostate
- ☐ Radiation therapy treatment management
- ☐ Transplantation of bone marrow
- ☐ NONE
- ☐ Other

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____
____
____

Past Surgical History

Have you had any surgeries on the following organs? **H/O = History Of**

- ☐ Abdominoperineal resection
- ☐ Bilateral replacement of knee joints
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ H/O: colostomy
- ☐ H/O tubal ligation
- ☐ H/O of appendectomy
- ☐ H/O bilateral mastectomy
- ☐ H/O cholecystectomy
- ☐ H/O colectomy
- ☐ H/O liver excision
- ☐ H/O percutaneous transluminal coronary angioplasty
- ☐ H/O tissue graft heart valve replacement
- ☐ H/O total cystectomy
- ☐ H/O transurethral prostatectomy
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy of breast
- ☐ Lumpectomy of left breast
- ☐ Lumpectomy of right breast
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous extraction of kidney stone with fragmentation procedure

Intake and History Form

- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ Surgical biopsy of skin
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total replacement of knee (right left)
- ☐ Total replacement of hip (right left)
- ☐ Transplant: Heart Liver
- ☐ None
- ☐ Other

____

____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asteatosis cutis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis due to poison ivy
- ☐ Dysplastic nevus of skin
- ☐ Eczema
- ☐ H/O asthma
- ☐ H/O hay fever
- ☐ Malignant Melanoma
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ 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?

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

____

____

Intake and History Form

Medications	Indication (Reason for taking)	Frequency/Amount

Drug Allergy	Reaction

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoked

Start Smoking:

- mm/dd/year - ____________________

Quit Smoking:

- mm/dd/year - ____________________

Number of Packs Per Day: __________

Alcohol Intake (please choose one):

- ☐ None
- ☐ >1 per day/socially
- ☐ 1-2 per day
- ☐ 3 or more per day

Illicit Drug Use Status:

- ☐ Never used
- ☐ Current user/Used in past 12 months
- ☐ Previous history of using

How often do you exercise?

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

____

What is your caffeine use?

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

Intake and History Form

Sexual Activity:

- ☐ Yes, one partner
- ☐ Yes, multiple partners
- ☐ No

Driving Status:

- ☐ Day
- ☐ Night

Occupation:

____

____

Do you feel safe at home?

- ☐ Yes
- ☐ No

Family Skin History

Please include only first-degree relatives with skin conditions:

____

____

____

For patients 65 and over ONLY:

Have you had your COVID-19 vaccination? ○ Yes ○ No

Do you have a health care proxy in the event you are unable to make your own medical decisions?

○ Yes ○ No

Designee's Name: ____
Designee's Phone Number: __________________________________

Do you have a living will?

○ Yes ○ No

Which statement best reflects your wishes on advanced care recommendations?

○ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

○ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

○ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or anyone older than 65? __________

Intake and History Form

Silver Leaf Dermatology & Graham Dermatology Center

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I will be provided, upon request, Silver Leaf Dermatology's (SLD) Notice of Privacy Practices. It tells me how SLD will use my health information for the purpose of my treatment, payment for my treatment, and SLD's health care operations. The notice explains in more detail how SLD may use and share my health information for other than treatment, payment, and health-care operations.
SLD will also use and share my health information as required by law.

Patient's complete Legal Name :____
Patient's SSN: ____________________________Patient's DOB :_____________________________
Signature :____Date:____________________
(Patient or legal representative* May be required to show proof of representative status)

SILVERLEAF DERMATOLOGY /GRAHAM DERMATOLOGY CENTER – SKIN EXAM ADVISORY

Welcome to our practice! Early detection of melanoma is of utmost importance. It is usually curable if found early. Later, it may require chemotherapy, which is often not very effective. In 20% of cases, melanoma is found in unexposed areas, and can arise from atypical moles or normal skin. Many skin lesions change through time, initially appearing normal and later becoming malignant. The American Academy of Dermatology and the National Cancer Institute recommend that all fair-skinned people have full-body exams yearly and more often if they have a history of atypical moles or melanoma. Signing below gives Dr. Graham and/or his assistants consent to examine your skin under clothed areas; your verbal consent may be given again or declined while in exam room. (Females are always examined in the presence of a female assistant.)

Please initial on choice below and sign at bottom.

______ Full Body Exam – time permitting.

______ Full Body Exam at my 1st Follow up appt and partial exam (from the waist up) today.

______ Only partial exam (from the waist up) today and do not wish to have the remainder. **I agree to full responsibility for any consequences that may result in failure to diagnose any type of skin cancer.**

______ No full body exam. **I agree to full responsibility for any consequences that may result in failure to diagnose any type of skin cancer.**

Signature of patient___________________________________ Date______________________

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Intake and History Form

PAYMENT POLICY

For your convenience, we attempt to verify your benefits before your visit. This allows us to focus on your care. We bill most insurance companies through an electronic payer number is shown on your card. If we later need to bill you because of an unmet deductible or lapse in coverage, the staff will call you to resolve the issue.

Self-pay rates will apply if insurance coverage cannot be verified. If there are any additional charges, we will advise you in advance. For additional credit, please inquire about our Care Credit. If you have suffered recent or severe financial hardship, please advise our staff, and an adjustment can be arranged.

Products and cosmetic procedures are paid separately and not billed to insurance. Products are refundable within 30 days if returned by you in person.

For surgical procedures, a 20% deposit (or copay) is required due to limited availability. Deposits are only refundable with a 24 hours' notice, unless you have a true emergency.

Specimens are submitted to D-Path for testing which may incur additional fees billed by them.

If the insurance company's explanation of benefits (EOB) later shows your share is less than the amount paid at your visit, we will promptly refund you the difference by account credit, or cashier's check within ten business days of our office being notified. Please fax your copy of the EOB to us at 405.216.0145 with a note indicating your refund preference type.

Please note: Providing excellent care to you is of greatest importance to us. We strive to make your visit a positive and valuable one. If you are not happy with your visit, please contact us immediately in person, email, or by phone so we may resolve the matter. We will work with you to achieve your full satisfaction. If for any reason the staff cannot resolve your concerns, please contact the doctor directly by email at silverleafderm@yahoo.com. If you have not received a response back within 24 hours, please give us a call.

I have read and have no further questions and wish to proceed with the visit based on above.

Signature:______________________________

Date: ______________________________

Name(Printed):______________________________