

Date of Visit: \_\_\_\_\_

# LIVONIA DERMATOLOGY NEW DEMOGRAPHICS

## ABOUT YOU

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone # \_\_\_\_\_ Other # \_\_\_\_\_ Sexual Orientation M F

SS # \_\_\_\_\_ Email Address \_\_\_\_\_

May we leave a message if Livonia Dermatology calls at any of the above numbers? YES NO

Pharmacy Name: \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_

Does your insurance restrict where we can send Lab and/or Pathology? YES NO

## HIPAA EMERGENCY CONTACT

Due to HIPAA laws, we must have written authorization to release information (*including biopsy results, appointments, etc.*) to someone other than yourself (spouse, child, parent). If you would like to grant permission to someone, please list them below:

Emergency Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about our office? (please circle)  
Dr. Referral - If so, which physician \_\_\_\_\_  
Radio - If so, which station \_\_\_\_\_  
Internet  
Friend or Family Member

## PRIMARY INSURANCE

Person financially responsible for this account (*Please circle*) PATIENT OTHER (*Name & Relationship*):

## IF SUBSCRIBER IS NOT THE PATIENT, PLEASE FILL OUT THE FOLLOWING:

Insured Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_ Address if not patient's \_\_\_\_\_

## INSURED PATIENTS – OTHER THAN MEDICARE (Please read and sign below)

Insurance cards and valid identification are necessary to keep on file at Livonia Dermatology for verification of patient and medical billing. I understand Livonia Dermatology is doing its part in preventing healthcare fraud and identity theft by using its own on-site server for all record usage. If I'm unable to provide current insurance and valid identification, I'll be considered a cash pay. I request payment of authorized insurance benefits be made to Livonia Dermatology for any services provided to me by this provider. I authorize any holder of medical information about me to be released to my insurance company(s) and its agents any information needed to determine benefits payable for related services. I give permission to Livonia Dermatology to appeal denied claims on my behalf (ERISA). This authorization is in effect until I choose to revoke it.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## MEDICARE PATIENTS ONLY (Please read and sign below)

I request payment of authorized Medicare benefits be made to me or on my behalf to Livonia Dermatology, P.L. L.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits payable for related services. The authorization is in effect for my lifetime or until I choose to revoke it.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**OFFICE CONSENT FORM**

Patient's Name \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

**CONSENT:** I consent to routine medical, routine office procedures, examinations, tests, immunizations, regional and local anesthesia and other treatment by David Pegouske, MD, Meena Moossavi, MD, and Stephanie Diamond, MD, or his/her assistants, associates or consultants as is necessary in their judgments. I know if I have any questions about my care or tests, I should be sure to ask the doctors/staff about them. I know it is up to me to tell the doctor/staff about any health problems or allergies. I must also tell the doctors/staff about any drugs or medications I am taking. I consent to the testing and disposal of specimens of my blood, urine, and other bodily fluids, tissues, products and that testing and disposal of my specimen may be conducted at an off-site facility/laboratory. I understand providers may bill separately. I understand that an HIV (human immunodeficiency virus) and /or HCV (hepatitis C virus) test may be done upon me without my consent if a doctor, health professional or employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid.

**NO GUARANTEES:** I understand the practice of medicine is not an exact science and no guarantees or promises have been made to me as a result of treatments or examinations by the doctor or assistants. I understand no contract, warranty, guarantee, or promise concerning the results of medical service is being made with regard to prognosis. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.

**SURGERY:** I understand surgery may be advised to treat various conditions and there are risks inherent to the performance of any surgical procedure such as blood loss, infection, reaction to anesthesia, numbness and/or lack of sensation, and formation of thick or otherwise objectionable scars. If I don't understand a procedure, the risks, consequences, and alternative treatments, I have the right to question the appropriate healthcare professionals or refuse treatment.

**MINOR PATIENTS:** Minor patients must be accompanied by a parent and/or legal guardian for the initial visit and any subsequent visit where a surgical procedure is performed. A signed authorization for subsequent office visits is acceptable. HOWEVER, payment is still required at time of service.

**NOTICE OF PRIVACY PRACTICE:** I have received a copy of Livonia Dermatology's Notice of Privacy Practices. I understand that additional copies of the notice will be provided to me upon request.

**RELEASE OF INFORMATION:** LIVONIA DERMATOLOGY, P.L.L.C (also known as Livonia Dermatology) releases patient information for purposes of treatment, or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practices. I understand that I may authorize a personal representative to have access to my protected health information. I understand I may terminate this authorization by submitting a written request to Livonia Dermatology.

**FINANCES: INSURED/NON-INSURED:** I understand I'm responsible for updating Livonia Dermatology with any insurance and/or demographic changes (address, phone number). I authorize the doctor and/or his representatives to review my insurance coverage with my insurance company and I authorize payment of benefits to be made directly to the doctor. I understand I'm responsible for understanding my benefits and coverage (which includes if this office is in my network). **I agree to pay, in full, any and all charges not covered by my insurance including co-payments, deductibles, and co-insurances and out of network fees.** I understand if I participate with a managed care plan, it's my responsibility to obtain the necessary referrals and/or authorizations. I understand it's my responsibility to notify Livonia Dermatology if my insurance requires laboratory specimens to be sent to a specific laboratory.  
**Non-insured: Payment is due at time of service for patients without insurance coverage or non-contracted insurances.**

**BALANCES/COLLECTIONS:** I understand Livonia Dermatology will mail a statement for any remaining balance and payment is due upon receipt. I understand that if additional statements (30 days/60 days from initial statement) are sent late charges will be assessed and I am responsible for those fees in addition to my balance. I understand it is the policy of Livonia Dermatology to turn delinquent (past 90 days) accounts over to a professional collection agency and the collection fee of at least 30% will be added to my balance. I understand that I may contact Livonia Dermatology for assistance in avoiding professional collection. As of January 1, 2015, credit cards will be required to be kept on file at Livonia Dermatology and will be used to charge any outstanding balances after the 30 day payment schedule. Patients will be notified upon charge on the credit card and will have the opportunity to make payment at that time.

**I CERTIFY THAT ANY AND ALL INFORMATION PROVIDED BY ME IN FURTHERANCE OF MY APPLICATION FOR HEALTH CARE BENEFITS ARE TRUE. I HAVE READ THIS FORM, ALL MY QUESTIONS REGARDING THIS FORM HAVE BEEN ANSWERED AND I UNDERSTAND ITS CONTENTS.**

\_\_\_\_\_  
PATIENT SIGNATURE\_\_\_\_\_  
DATE\_\_\_\_\_  
PERSONAL REPRESENTATIVE SIGNATURE  
(IF PATIENT UNDER 18)\_\_\_\_\_  
RELATIONSHIP\_\_\_\_\_  
DATE

**LIVONIA DERMATOLOGY PATIENT QUESTIONNAIRE**

Today's Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Please provide the following medical information to the best of your ability:

List any allergies to medications and reactions:

Medication: \_\_\_\_\_ Allergic Reaction: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please check the "Yes" or "No" box to indicate if you **have/had** any of the following illnesses and **if so**, check the med's box if you are taking medication for it.

	YES	NO	MED'S		YES	NO	MED'S
ARTHRITIS/JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH OR INTESTINAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE/CHOLESTEROL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKIN CANCER/TYPE _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKIN DISEASE/TYPE _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER OTHER THAN SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**Please list your current doctors:**

\_\_\_\_\_  
 \_\_\_\_\_

**Please list any OPERATIONS/HOSPITALIZATIONS (and dates) you have ever had.**

\_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? \_\_\_\_\_ YES \_\_\_\_\_ NO      Have you ever been exposed to Hepatitis B/C? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If yes, amount \_\_\_\_\_      Have you ever had blistering sunburns? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If no, did you smoke previously? \_\_\_\_\_ YES      Do you use sun screen? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 Do you drink alcoholic beverages? \_\_\_\_\_ YES \_\_\_\_\_ NO      If yes, SPF \_\_\_\_\_  
 Is yes, frequency \_\_\_\_\_      Have you been exposed to T.B? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 Have you been exposed to HIV? \_\_\_\_\_ YES \_\_\_\_\_ NO

**FEMALE PATIENTS CHILD BEARING AGE PLEASE ANSWER THE FOLLOWING:**

Are you pregnant? \_\_\_\_\_ YES \_\_\_\_\_ NO      Breast feeding? \_\_\_\_\_ YES \_\_\_\_\_ NO      Planning a pregnancy? \_\_\_\_\_ YES \_\_\_\_\_ NO

**FAMILY HISTORY**

Please check the box to indicate if any family members HAVE or HAD the conditions listed.

<b>Condition</b>	<b>Mother</b>	<b>Father</b>	<b>Siblings</b>	<b>Other</b>	<b>Comment/Type</b>
DIABETES (if yes, what type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SKIN CANCER (if yes, what type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SKIN DISEASES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ECZEMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSORIASIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER (what type, if known)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Today's Date: \_\_\_\_\_

Please provide the following medical information to the best of your ability:

**Review of systems**

1. Please check the "YES" or "NO" box to indicate if you have any of the following symptoms AND
2. For any "YES" responses, check the "CURRENT" box if this symptom relates to the reason for your visit today.

		YES	NO	CURRENT			YES	NO	CURRENT
GENERAL	CHILLS				HEME/ LYM	SWOLLEN GLANDS			
	FEVER					BLEEDING PROBLEMS			
	WEIGHT LOSS/GAIN					RECURRENT INFECTIONS			
ALLERGY	ITCHY EYES					SWEATING AT NIGHT			
	WATERY EYES					EASY BRUISING			
NEURO	HEADACHES				NAILS	DISCOLORED			
	SEIZURES					PAINFUL			
	WEAKNESS IN LIMBS					BRITTLE			
	NUMBNESS/TINGLING					LOOSE			
EYES	VISION CHANGES				PSYCH	DEPRESSION			
	PAIN/PRESSURE					ANXIETY			
ENT	HEARING LOSS				SKIN	RASH			
	DIZZINESS					MOLE CHANGES			
	LIGHTHEADEDNESS					REDNESS			
RESPIRATORY	COUGH					RAISED SCALY AREAS			
	SHORTNESS OF BREATH					OPEN SORES			
CVS	CHEST PAIN					ACNE			
	VARICOSE VEINS					GROWTHS/SPOTS			
	ANKLE SWELLING					HAIR LOSS			
G.I.	HEARTBURN					SUN SUSCEPTIBILITY			
	DIFFICULTY SWALLOWING					ITCHING			
G.U.	PROSTATE PROBLEMS				HIVES				
	FREQUENT URINATION				BLISTERING SUNBURN				
MUSK	JOINT ACHES				KELOIDS SCARS				
	BACK PAIN				DRY MOUTH/NOSE				
ENDO	EXCESSIVE SWEATING				DRY SKIN				
	EXCESSIVE THIRST				JAUNDICE				
	INTOLERANCE HEAT/COLD				HAVE YOU EVER HAD A SKIN BIOPSY?				

My signature affirms I have completed this form accurately and completely to the best of my ability:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE STOP HERE – OFFICE USE ONLY**

Subsequent Review/Comments

---



---



---



---

History Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Staff Signature \_\_\_\_\_  
 History Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Physician Signature \_\_\_\_\_

