Date of Visit: _______________

LIVONIA DERMATOLOGY
NEW DEMOGRAPHICS

ABOUT YOU

Name of Patient ______________________ Date of Birth ______________

Home Address ______________________ City ______________ State ______ Zip Code ______

Primary Phone # ______________________ Other # ______________ Gender 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**

Date of Visit: _______________

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	☐	☐	☐	STOMACH OR INTESTINAL PROBLEMS	☐	☐	☐
DIABETES	☐	☐	☐	ALLERGIES	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	KIDNEY PROBLEMS	☐	☐	☐
THYROID PROBLEMS	☐	☐	☐	NEUROLOGICAL DISORDERS	☐	☐	☐
HEART DISEASE/CHOLESTEROL PROBLEMS	☐	☐	☐	STROKE	☐	☐	☐
RESPIRATORY PROBLEMS	☐	☐	☐	SKIN CANCER/TYPE _____________	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	SKIN DISEASE/TYPE _____________	☐	☐	☐
CANCER OTHER THAN SKIN	☐	☐	☐				

Please list your current doctors:

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

SOCIAL HISTORY

Do you smoke? ____ YES ____ NO

If yes, amount ______________

If no, did you smoke previously? ____ YES

Do you drink alcoholic beverages?____ YES ____ NO

Is yes, frequency ___________

Have you been exposed to HIV? ____ YES ____ NO

Have you ever been exposed to Hepatitis B/C? ____ YES _____ NO

Have you ever had blistering sunburns? ____ YES _____ NO

Do you use sun screen? ____ YES _____ NO

If yes, SPF ________________

Have you been exposed to T.B? ____ 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.

Condition	Mother	Father	Siblings	Other	Comment/Type
DIABETES *(if yes, what type)*	☐	☐	☐	☐	
SKIN CANCER *(if yes, what type)*	☐	☐	☐	☐	
BLEEDING DISORDER	☐	☐	☐	☐	
SKIN DISEASES	☐	☐	☐	☐	
ECZEMA	☐	☐	☐	☐	
PSORIASIS	☐	☐	☐	☐	
CANCER *(what type, if known)*	☐	☐	☐	☐	

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
GENERAL	CHILLS			
	FEVER			
	WEIGHT LOSS/GAIN			
ALLERGY	ITCHY EYES			
	WATERY EYES			
NEURO	HEADACHES			
	SEIZURES			
	WEAKNESS IN LIMBS			
	NUMBNESS/TINGLING			
EYES	VISION CHANGES			
	PAIN/PRESSURE			
ENT	HEARING LOSS			
	DIZZINESS			
	LIGHTHEADEDNESS			
RESPIRATORY	COUGH			
	SHORTNESS OF BREATH			
CVS	CHEST PAIN			
	VARICOSE VEINS			
	ANKLE SWELLING			
G.I.	HEARTBURN			
	DIFFICULTY SWALLOWING			
G.U.	PROSTATE PROBLEMS			
	FREQUENT URINATION			
MUSK	JOINT ACHES			
	BACK PAIN			
ENDO	EXCESSIVE SWEATING			
	EXCESSIVE THIRST			
	INTOLERANCE HEAT/COLD			

		YES	NO	CURRENT
HEME/ LYM	SWOLLEN GLANDS			
	BLEEDING PROBLEMS			
	RECURRENT INFECTIONS			
	SWEATING AT NIGHT			
	EASY BRUISING			
NAILS	DISCOLORED			
	PAINFUL			
	BRITTLE			
	LOOSE			
PSYCH	DEPRESSION			
	ANXIETY			
SKIN	RASH			
	MOLE CHANGES			
	REDNESS			
	RAISED SCALY AREAS			
	OPEN SORES			
	ACNE			
	GROWTHS/SPOTS			
	HAIR LOSS			
	SUN SUSCEPTIBILITY			
	ITCHING			
	HIVES			
	BLISTERING SUNBURN			
	KELOIDS SCARS			
	DRY MOUTH/NOSE			
	DRY SKIN			
	JAUNDICE			
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 ____________________

CURRENT MEDICATIONS Today's Date: ___________________

Patient Name ___________________________________ Date of Birth _________________

Please list any medications to which you are allergic: Initial Date of Service ______________

1.______________________________ 3. ______________________

2.______________________________ 4. ______________________

Patient Use *(Please list all medications including anything "over the counter")*				***Office Use***		
Medication	Strength	Directions	Reason for Taking	*Ord'd by Livonia Derm.*	*Date DC'd*	*Staff Comments*

Rev'd Date/Initials: ______________/__________/__________/__________/__________/__________/____