Heidi H. Cole, M.D.

Medical, Surgical, and Cosmetic Dermatology

HEALTH INFORMATION

Name:_____ Telephone: _____

Today's Date:_____ Current Age:_____ Date of Birth:_____

Education (Highest Level Attained): _____

Occupation: _____

Have you ever had a job working outdoors? _____ If yes, what type and how long? _____

MEDICAL HISTORY - Please circle any conditions you have had:

Diabetes	Heart Disease	Cancer (Type: _____)	Stroke	Bleeding Tendency	High Blood Pressure
Allergy	Kidney Disease	Nervous Disorder	Tuberculosis	Venereal Disease	Glaucoma
Stomach Ulcers	Asthma	Pneumonia	Rheumatic Fever	Hepatitis	Vein Trouble

Other:_____

PREVIOUS OPERATIONS - Please list giving date:

_____

_____

_____

MEDICATIONS - Please name or otherwise identify medications now used:

_____

_____

_____

Physican Name: _____ Phone Number:_____

HAVE YOU HAD ALLERGIES OR SENSITIVITIES TO ANY MEDICATIONS OR OTHER SUBSTANCES? _____ If yes, please describe:_____

Do you use tobacco now?_____ In the past?_____ Type and daily amount?_____ How Long? _____

Do you use alcoholic beverage?_____ In the past?_____ Type?_____ Weekly Amount?_____ How Long? _____

MENSTRUAL HISTORY (If applicable):

Date of last period:_____ Periods are regular:_____ Irregular: _____

Number of pregnancies?_____ Number of miscarriages?_____ Do you take birth control pills? _____

SKIN HISTORY

Are you Caucasian_____ African American_____ Hispanic _____ Asian_____ Multiracial_____ Other _____

When you go out in the sun, do you - Please choose one:

Always burn, never tan _____ Usually burn, tan difficulty _____ Sometimes burn, usually tan_____ Rarely burn, tan easily_____

Have you ever had skin cancer? _____ If yes, was it melanoma?_____

Has a family member ever had skin cancer?_____ If yes, was it melanoma? _____

Have you ever had moles removed? _____ Do you have any moles which have recently changed color, size or shape? _____

Do you use tanning beds?_____ Lie out in the sun?_____ Use sunscreen?_____

REASON FOR YOUR VISIT: _____

_____

HOW DID YOU LEARN ABOUT OUR PRACTICE:

Referred by physician (give name): _____

Referred by friend (give name):_____

Yellow Pages _____ Insurance Booklet_____ Other_____

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PATIENT INFORMATION

Patient's Name:_____ Birth Date:_____ M/F

Home Address:_____

City/State:_____ Zip:_____

Daytime Phone Number:_____ Evening Phone Number:_____

Cell Phone Number:_____

Marital Status: S M W D Spouse's name (if married) or Parent's name (if under 18)_____

Employer's Name:_____ Phone:_____

Spouse's Employer:_____ Phone:_____

Person to Contact for Emergency:_____ Phone:_____

Name of Policyholder:_____ Date of Birth:_____

Is this: ☐ Yourself ☐ Spouse ☐ Parent ☐ Other (Explain)_____

Name of Insurance Company:_____

Policy Number:_____ Group Number:_____

If you have any secondary or supplemental insurance, please provide the name & policy number:_____

_____

Person Responsible for Bill:_____

Address:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account. I have read all information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature:_____ Date:_____

Parent's (if minor):_____ Date:_____

ASSIGNMENT OF BENEFITS

I request that payment of benefits be made either to me or on my behalf to Dr. Heidi Cole, Dermatology, for services furnished me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

Heidi H. Cole, M.D.

Dear Patient:

This clinic understands the necessity of protecting and safeguarding the personal information of our patients from improper use or disclosure. In order to ensure this, the clinic will: **OBTAIN ROUTINE CONSENTS,** as necessary, to permit the use of personal health information for current, future and/or routine needs. These consents will include the use and release of personal information for purposes of payment, treatment, and health care operations.

Special consents, (also known as **AUTHORIZATIONS**) will be obtained, as appropriate, prior to the use or release of information beyond the scope of the routine consent. When a person is unable to provide consent, an appropriate individual is identified to give consent on his or her behalf.

ACCESS TO HEALTH RECORDS AND INFORMATION

Patients may access their own health records. The definition of "patient" also includes the surviving spouse, the family of a deceased patient or a person the patient appoints in writing as their legally recognized representative. Patients also have the right to amend their health records. Patients will be referred to their provider to discuss information maintained in their record.

A person may not access their living spouse's personal information without an authorization (or consent) from the patient.

A parent or legal guardian of a minor may access and authorize the release of the minor's health information. However, if the minor is married, emancipated, had borne a child, or if the records in question concern venereal disease, chemical dependency, or pregnancy, and related conditions, the parent or legal guardian may not access or release the minors health information without the minors express written consent.

Health information may be withheld from a person only if a physician or other licensed health care provider reasonably determines that information will be detrimental to his or her physical or mental health or is likely to cause him or her to inflict self-harm or harm to another. The practitioner must record and state the specific reason why they are withholding information prior to the request.

A patient may request restrictions on the use and disclosure of their health information.

In order to comply with evolving laws and standards, this clinic may occasionally modify its privacy practices. If you have any questions regarding the privacy guidelines, please feel free to contact your practitioner.

I have been given the opportunity to read this before signing.

Date _____ Signature _____