Medical History Form

Family Dermatology

5603 Duraleigh Rd, Suite 111, Raleigh, NC 27612 || 860 Perry Road, Apex, NC 27502

919-791-0840

Chart # (the office will write this in): _____

Name: _____ Gender: _____ Age: _____

Patient race: _____ Ethnicity: _____

Preferred language: _____

How did you hear about us (who referred you?): _____

Please list your primary care physician: _____

Please list any other providers you would like your office notes sent to: _____

_____

Please provide your e-mail for appointment reminders: _____

Reason(s) for today's visit:

1. _____

2. _____

Have you had an atypical (dysplastic) mole biopsied? _____

Have you had a basal or squamous cell carcinoma? _____

Have you had a melanoma? _____

Has your father, mother, brother, sister, son or daughter had a melanoma? _____

Do you have a history of any other cancer? _____

Do you smoke or use other tobacco? __Current smoker __Former __Never

Do you now or have you ever had (please check what applies):

__Artificial heart valve	__Diabetes	__Lupus
__Artificial joint (knee, etc.)	__Hypertension	__Arthritis
__Pacemaker	__Hepatitis B	__Thyroid disease
__Defibrillator	__Hepatitis C	
__HIV or AIDS	__Radiation treatment (if so list body parts): _____	

Any other disease or condition we should know about? _____

Please provide a phone number where we can reach you during the day: _____

May we speak with your family members regarding your problems and test results? _____

Do you have any cosmetic concerns? _____

Medicare Patients

Name and # of health care proxy if you have one: _____

Do you have a living will? _____

Which best reflects your wishes: ___Do not resuscitate __Do not intubate __Do it all!

Have you received the pneumonia vaccine (Pneumovax)? _____

Women

Are you pregnant? ____

Breastfeeding? ____

Planning pregnancy? ____

Please sign below acknowledging you have reviewed our privacy and financial policies (copies are located at the check in desk). _____ _____

Signature Date

Chart #: _____

Name: _____

DOB: _____

Are you allergic to latex, lidocaine, or any other medications? _____

Are you allergic to adhesive? _____

List drug(s) and reaction(s): _____

Are you on a blood thinner? _____

List all medications, over-the-counter supplements and vitamins that you take daily, or as needed (include dosage and frequency):

Drug Name	Dose	Frequency

Pharmacy Information

Name of pharmacy: _____

Address: _____

FAMILY DERMATOLOGY

A Division of Raleigh Medical Group
MATTHEW FLYNN, M.D KARA E. BROOKS, M.D.
ROBERT H. JOHR, M.D SHAILY P. BHATNAGAR, M.D.
KELLY T. BLOUNT, P.A.-C GINGER E. SMITH, P.A.-C
ANDREW SCHANO, P.A.-C Beth MacPherson, FNP-BC
5603 DURALEIGH ROAD, SUITE 111, RALEIGH, NC 27612
860 PERRY ROAD, APEX, NC 27502
TELEPHONE: 919-791-0840
FAX: 919-791-0911

Patient Name: _____

Federal law prohibits this practice from sending you texts or e-mail which are unencrypted or "unsecure." However, many patients find it convenient to communicate with our office by traditional text and/or e-mail. Those modes of communication are generally not considered "secure." Some patients appreciate the tradeoff between ease of use/convenience and security. We want to accommodate your preferences. If you would like to communicate with us by "unsecure" text and/or e-mail, please confirm below by providing your authorization. We will keep your preferences in form with no current expiration date until we learn otherwise. Obviously, you can change your mind at any point down the road. Just let us know in writing so we can stay updated with your preference(s). If messages are sent through such channels, they may no longer be protected by HIPAA. Finally, whether or not you decide to use e-mail or text messaging, your choice will have no impact on our decision to treat you. We are here for you.

I authorize the practice to communicate with me by "unsecure" text; that text number being:

_____ _____
Phone Number Signature

I authorize the practice to communicate with me by "unsecure" e-mail; that e-mail address being:

_____ _____
E-mail Address Signature

I decline the option to be communicated with via "unsecure" text or e-mail.

Signature: _____ Date: _____

FAMILY DERMATOLOGY

A Division of Raleigh Medical Group

MATTHEW FLYNN, M.D KARA E. BROOKS, M.D.

ROBERT H. JOHR, M.D. SHAILY P. BHATNAGAR, M.D.

KELLY T. BLOUNT, P.A.-C GINGER E. SMITH, P.A.-C

ANDREW SCHANO, P.A.-C Beth MacPherson, FNP-BC

5603 DURALEIGH ROAD, SUITE 111, RALEIGH, NC 27612

860 PERRY ROAD, APEX, NC 27502

TELEPHONE: 919-791-0840

FAX: 919-791-0911

Deductibles, Co-Insurance, and Co-Pays

Your employer group may have elected to offer a health plan that requires you to meet a deductible, pay a co-insurance, or co-pay. If your deductible to maximum out-of-pocket as defined by your benefits has not been met upon our eligibility verification, we will collect these balances at the time of service.

Office Procedures

If you have a deductible for surgery, you may have to pay out-of-pocket for certain minor procedures performed in this office. Your insurance company may define these procedures as "office surgery" and force you to pay that part of the bill. Examples of these procedures include:

1. Destruction of lesions by any method including liquid nitrogen, electro-cauterization, or Canthacur ("beetle juice")
2. Removal of skin tags
3. Biopsy of any method
4. Shave removal of lesions

We do not consider these procedures to be surgery. We bill for these using government-mandated procedure codes. This is usually the only legal way to do it. If your insurance company calls one of these minor procedures "surgery," that is their decision, not a billing choice we make.

Pathology Services

Tissue samples removed by biopsy, shave removal, or excision will be sent to a Pathology lab. We have no financial relationship with them. If you have questions regarding a Pathology bill you received, please contact the Pathology lab at the number provided on the bill.

Cosmetic Removal of Moles

All moles must now be sent to Pathology, even if removed for cosmetic reasons. This is standard of care. This results in a separate bill from the Pathology lab.

Cosmetic Removal of Skin Tags

Removal of skin tags are considered cosmetic by insurance carriers. If the skin tag is currently showing signs of inflammation, crusting, and/or bleeding, your insurance carrier *may* consider the removal of skin tags medically necessary. The provider will evaluate and determine if the skin tag is cosmetic.

Name: _____

Date of birth: _____

Today's date: _____

Time of Appointment: _____

Please check all that apply:

□ Shortness of breath

□ Difficulty breathing

□ Coughing

□ Sneezing (including allergies)

□ Runny Nose

□ Sore throat

□ Fever

□ Traveled out of the country in the last 30 days

If so, where? _____

□ Traveled out of the state (domestically) in the last 30 days

If so, where and method of transportation?

_____

□ Have come in contact with someone that has been tested for Covid-19

□ Been in a crowd with 10 people or more with less than 6 six feet of distance

□ Work in a healthcare setting that would put you in a higher risk

□ If none of the above apply to you, check this box!

Surgery During COVID
Patient Authorization and Consent Form

On March 11, 2020, the World Health Organization declared the COVID-19 disease a pandemic. As a result, many hospitals and surgery centers put a hold on all elective and non-urgent procedures and surgeries. This was part of an effort to save personal protective equipment (PPE) for frontline healthcare workers treating COVID-19 patients.

In many areas of the country, there is enough PPE, and elective/non-urgent procedures and surgeries are resuming. However, there is still a risk for performing these procedures and surgeries during the COVID-19 pandemic. These risks include but are not limited to exposure to other patients, healthcare staff, and healthcare facilities.

More Facts

I understand that COVID-19 is very contagious. It is most likely spread by person-to-person contact. I understand that my doctor and his or her staff will follow all laws and recommendations from local, state, and national health officials. However, there are still risks of being infected with COVID-19 during a procedure or surgery. I agree to assume the risks, and I give permission for my doctor and the staff to perform a procedure or surgery on me.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

Some risks are not yet known. I understand that if I have one or more of these conditions, I may have a higher chance for 1) getting COVID-19 and 2) health problems if I get COVID-19. I understand that these problems may be serious. I may have to be in the hospital for a long time and could even die.

I understand that possible exposure to COVID-19 before, during, or after my procedure or surgery may result in: a COVID-19 diagnosis, a long quarantine or self-isolation, more tests, being in the hospital, intensive care treatment, intubation/ventilator support, short-term or long-term intubation, other complications, and the risk of death. Also, after my elective/non-urgent procedure or surgery, I may need to go to an emergency room or a hospital for care. I have been given the option to wait until a later date to have my procedure/surgery.

I understand all of the risks, including but not limited to the potential problems related to COVID-19, and I would like to proceed with the procedure/surgery.

In Office Visit During COVID
Patient Authorization and Consent Form

During the COVID-19 pandemic, there is some increased risk for patients who visit a healthcare provider. Health problems can happen from being exposed to:

- other patients,
- healthcare staff, or
- healthcare facilities.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

If these high-risk patients get COVID-19, they may have a greater chance for having more health problems. These may be serious. Patients may need to be in the hospital. They could even die.

Other Evaluation and Treatment Choices

There may be other ways to meet with your doctor and be treated. You could have:

- a phone evaluation or
- a telehealth evaluation.

These other options may or may not be right for you. This depends on your health problem and overall health. If remote assessment and treatment are not appropriate, your doctor will explain why you need an in-person visit.

More Facts

Medical and office staff may help your doctor when you arrive and while you are evaluated and treated. They will follow state laws and recommendations from local, state, and national health officials related to caring for patients during the COVID-19 pandemic. However, they cannot eliminate risks, especially for high-risk patients.

Consent to Treatment

_____The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, **do not sign the form until all questions have been answered.**

_____I understand the facts provided to me on the first page of this consent form. I give my consent for in-office evaluation and treatment. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all of my questions have been answered.

_____ _____
Signature of Patient or Responsible Party Date and Time

_____
Relationship to Patient (if Responsible Party is not Patient)

_____ _____
Witness Date and Time