



**PATIENT INFORMATION**

Appointment Date \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State/Zip: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

DOB/Age \_\_\_\_\_ SSN \_\_\_\_\_ Gender \_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_

Preferred Language \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician (PCP) \_\_\_\_\_ Pharmacy/Location \_\_\_\_\_

Email Address \_\_\_\_\_

How did you hear about McDaniel Dermatology? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**INSURANCE INFORMATION/RESPONSIBLE PARTY**  
*(IF APPLICABLE, PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST)*

Is the patient covered by insurance? \_\_\_\_\_ If yes, are there multiple insurers? \_\_\_\_\_

If applicable, please list the filing order \_\_\_\_\_

Insured/Responsible Party \_\_\_\_\_ Preferred Phone \_\_\_\_\_ DOB \_\_\_\_\_

SSN \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**IN CASE OF EMERGENCY**

Who may we contact? \_\_\_\_\_ Relationship to patient? \_\_\_\_\_

Best contact number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

- I authorize and request that insurance benefits be paid directly to McDaniel Dermatology should we elect to bill my insurance company.
- I understand that I am financially responsible for any balance if not covered by insurance.
- I authorize the release of my Personal Health Information to the referring physician, my insurance company, and laboratories, if applicable, for the purpose of treatment, payment, clinical management and administrative duties.
- I have been given the opportunity to review and/or receive a copy of McDaniel Dermatology & Skin Surgery Institute’s Notice of Privacy Practices.

\_\_\_\_\_  
 Patient/Parent signature

\_\_\_\_\_  
 Date



**Past Medical History**

**Patient Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

*Please circle all that apply to you in each section*

Anxiety	Leukemia	GERD	Stents	Hypertension
Depression	Asthma	Lymphoma	Hepatitis	Colon Cancer
Hypothyroidism	Kidney disease	BPH	Radiation Treatment	HIV/AIDS
Arthritis	Lung cancer	Hearing Loss	Breast Cancer	Stroke
Diabetes	Atrial fibrillation	Prostate Cancer	Seizures	COPD
Hypercholesterolemia	Coronary Artery disease	Hyperthyroidism	Bone Marrow Transplant	

Other: \_\_\_\_\_

**SKIN SURGERIES**

Skin Biopsy	Basal Cell Carcinoma	Melanoma	Squamous Cell Carcinoma
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Other: \_\_\_\_\_

**SKIN DISEASE HISTORY**

Dry Skin	Actinic Keratosis	Precancerous Moles	Flaking or Itching Scalp	Blistering Sunburns
Poison Ivy	Psoriasis	Eczema	Rosacea	Melanoma
Acne	Hay Fever/Allergies	Basal Cell Carcinoma	Squamous Cell Skin Cancer	

Other: \_\_\_\_\_

**FAMILY HISTORY**

Do you have a family history of melanoma?	yes _____ no _____	If yes, which relative?
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**MEDICATIONS**

Current medications?	Are you allergic to any medications?
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**SOCIAL HISTORY**

Currently smokes	Has smoked in the past	Never smoked
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**ALCOHOL USE**

Everyday Drinker	Social Drinker	Never Drinker
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Any recreational drug uses? \_\_\_\_\_

**ROS**

any new allergies	changing moles	problems with bleeding	problems with scarring (hypertrophic or keloid)	immunosuppression
rash	depression	blood thinners	Rapid heartbeat with epinephrine	artificial joints within the past two years
allergy to lidocaine	yeast infections with antibiotics	artificial heart valve	premedication prior to procedures	artificial heart valve
allergy to adhesive	allergy to topical antibiotic ointments	pacemaker or defibrillator	pregnant	planning a pregnancy



### Supplemental Patient Intake

*Due to new requirements from the US Department of Health and Human Resources, we are requesting that all patients complete the following questionnaire.*

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX:  Male  Female

#### **Melanoma:**

Have you ever been diagnosed with Melanoma?  YES  NO

If YES, did you ever have an X-ray, CT Scan, MRI, or PET Scan?  YES  NO

#### **Tobacco Use:**

Please choose the option that best describes your tobacco use:

Never  Current smoker  Previous smoker  Less than 100 cigarettes in lifetime

For current tobacco users, select the option that best describes use:

1-3 cigarettes per day  Up to 1 pack per day  1-2 packs per day  2 or more packs a day

#### **Vaccinations:**

In the past year, did you receive the following vaccinations?

Flu vaccine:  YES  NO

COVID-19 vaccine:  YES  NO

(65 YRS OLD AND OVER ONLY) Pneumonia vaccine:  YES  NO

#### **Pain:**

Aside from general aches (i.e. muscle, head, tooth), are you currently experiencing any pain?

YES  NO

If yes, please circle the number that corresponds with the amount of pain you are currently in:

1      2      3      4      5      6      7      8      9      10

#### **AGE 65 AND OVER ONLY:**

Do you have one of the following?

Power of Attorney (Surrogate Decision Maker)  Living Will (Advance Care Plan)  None



**Request for Medical Treatment**

I, \_\_\_\_\_, have presented to McDaniel Dermatology & Skin Surgery Institute to obtain medical treatment for myself or my child.

I understand that in order to adequately treat or diagnose my condition, I may need to have a biopsy performed or have a lesion frozen with liquid nitrogen, removed with a curate, surgically excised, or burned off. Some risks are associated with these procedures including scarring that may look worse than the original scar, lightening or darkening of the skin, bleeding, infection, and a change in sensation. Some insurance companies may not include procedures as part of an office visit. If the procedure is done, according to your insurance plan, it may fall under a procedure deductible and you will have to pay according to your plan.

If Dr. McDaniel feels that one of these procedures is necessary for me or my child’s treatment, she will discuss this with me before proceeding with the procedure. I will be given the opportunity to ask any questions about the procedure as well as refused the recommended procedure.

I am also aware that if a biopsy or culture is done, it will be sent to an outside laboratory where it will be processed and filed to my insurance. Therefore, according to my personal insurance plan, I may have additional fees from the lab.

By signing this, I knowledge that I have read and understand above information.

\_\_\_\_\_  
Patient/Parent signature

\_\_\_\_\_  
Date

\_\_\_\_\_ I authorize McDaniel Dermatology & Skin Surgery Institute to give my test results to:

\_\_\_\_\_  
Provide Name & Contact Information

\_\_\_\_\_ I do not authorize my results to be given to anyone other than myself.



### **Cancellation and No-Show Policy**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you must provide at least 24-hour notice. You must provide 48-hour notice for a surgical appointment to avoid a no-show fee. This will enable us to accommodate another patient who is waiting for an appointment.

Patients who do not show up for a scheduled appointment, and who have not contacted our office at least the day before the appointment will be considered a no-show.

- Appointments which are not canceled within 24 hours will be charged a \$30 fee. Procedure cancellations require two-day notice; without notification they are subject to a \$250 cancellation fee, or the retention of the deposit.
- This fee is charged the patient, not the insurance company, and is due at the time of the missed appointment.
- Patients who no-show two or more times in a 12 month may be dismissed from the practice and will be denied future appointments.

We do realize circumstances can change at the last minute. If you were unable to make a schedule appointment due to extenuating circumstances, please contact our practice administrator at 985-277-5463 who me be able to waive the no-show fee.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date



**Patient Authorization for Release of Protected Health Information**

By signing this authorization, I authorize McDaniel Dermatology & Skin Surgery Institute to use and/or disclose certain protected health information (PHI) about me to \_\_\_\_\_ (*name of entity to receive this information*). This authorization permits McDaniel Dermatology & Skin Surgery Institute to use and/or disclose the following individual’s identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, level of detail to be released, origin of information, etc.):

\_\_\_\_\_

The information will be used or disclosed for the following purpose:

\_\_\_\_\_

If requested by the patient, purpose may be listed as “at the request of the individual.”

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on \_\_\_\_\_ (*expiration date or defined event*).

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient’s Name/Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

**Patient/Guardian to be provided with a signed copy of this authorization.**



**McDANIEL**  
 DERMATOLOGY & SKIN SURGERY INSTITUTE  
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**- AUTHORIZATION TO RELEASE HEALTH INFORMATION -**

Patient Name		Date of Birth
Social Security Number		
Address		

* Provider authorized to release the Health Information (the "Provider"):	(Name of releasing entity)
* Entity to receive the Health Information (the "Recipient"):	(Name of receiving entity)
Recipient's Address:	Address
	Attention:

* Dates of service of the Health Information that is covered by this authorization:	
Start date:	End date:
Start date:	End date:

* Health information related to the patient to be released under this authorization:	
Complete health record	
Discharge summary	Progress Notes
History & physical examination	Laboratory tests
Consultation reports	X-ray report
Other (Please specify):	

The following information will be released when included in the above unless you indicate otherwise:	
Do not release any AIDS or HIV test results	Do not release any records of psychiatric care
Do not release any records of alcohol/substance abuse treatment	
Other:	

<input type="checkbox"/> If checked, this authorization allows the Provider to use or disclose your information for marketing purposes and the Provider receives direct or indirect remuneration from a third party for that marketing use or disclosure.
<input type="checkbox"/> If checked, this is a conditional authorization, and you will not receive the following services unless you sign this authorization (describe any consequences of refusing to sign):

* Purpose of disclosure:
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* Authorization expiration date or event:
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* Patient's Signature	Date
* Personal representative's signature (if necessary)	Date

*Note: If signed by a "personal representative" of the patient, please complete the Personal Representative section on the back.*

Not to be used for release of genetic test.



## Cosmetic Interest Questionnaire

Date: \_\_\_\_\_

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

When I look in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

I am interested in a skincare routine that is most appropriate for my skin type and age.

YES  No thanks

I am interested in learning about anti aging products and or procedures.

YES  No thanks

**Please indicate the aesthetic treatments and procedures that interest you. Please check all that apply.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Skin care advice<br><input type="checkbox"/> Facial lines and wrinkles<br><input type="checkbox"/> Sun spots/Age spots/Freckles<br><input type="checkbox"/> Facial redness / Blotchy skin<br><input type="checkbox"/> Sun damage to neck and declotee<br><input type="checkbox"/> Length/fullness of eyelashes<br><input type="checkbox"/> Professional skin-care products<br><input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> Hair removal<br><input type="checkbox"/> Topical wrinkle treatments<br><input type="checkbox"/> Skin rejuvenation<br><input type="checkbox"/> Thin lips<br><input type="checkbox"/> Silkpeel/Microdermabrasion<br><input type="checkbox"/> Dermal fillers for fine lines and wrinkles | <input type="checkbox"/> Botox/Dysport (Botulinum toxin A)<br><input type="checkbox"/> Mineral makeup<br><input type="checkbox"/> Sunscreen advice<br><input type="checkbox"/> Acne treatment |
|---|--|---|

### PLEASE MARK THE DIAGRAM TO INDICATE YOUR CONCERNS

