

WELCOME TO OUR OFFICE. PLEASE FILL OUT THIS FORM COMPLETELY

Date: _____

Patient Information:

Patient Name: _____ Nickname: _____ Birthday: _____

Home Phone: (____) _____ Sex (Circle One): M or F Age: _____

Home Address: _____ City: _____ Zip _____

Email Address: _____

Name of Parent/ Legal Guardian: _____ Patient's Primary Physician: _____

Referred By: _____

Employer: _____ Work Phone: (____) _____

Work Address: _____ City: _____ Zip _____

Soc. Sec. # (If Insur. Requires) : _____ Cell Phone: (____) _____

Marital Status: _____ Spouse: _____

Phone: (____) _____ Birthdate: _____ Age: _____ Sex: _____

EMERGENCY CONTACT:

Name: _____ Phone: (____) _____ Relationship: _____

If someone other than patient is responsible for payment, complete below

Name: _____ Phone : (____) _____

Address: _____ SS#: _____

Insurance Information:

Primary Carrier: _____ Co-Payment: _____

Secondary Carrier: _____ Co-Payment: _____

As patient or as legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to Dr. Kristin Walker, M.D., INC. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

Date: _____ Signed: _____

All Medicare patients must sign a lifetime beneficiary claim authorization: I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Dr. Kristen Walker, M.D., INC. for any services furnished to me by that physician.

Date: _____ Signed: _____

PATIENT HISTORY FORM

All information contained below is confidential.

NAME: _____ FAMILY M.D.: _____

DATE: _____ OCCUPATION: _____

CURRENT MEDICATIONS (incl. topical and over-the-counter)

ALLERGIES TO MEDICATIONS

Have you ever been diagnosed with skin cancer? If so, what kind and where was it located?

Have you ever been diagnosed with melanoma? If so, what level and where was it located?

Have you ever been treated for skin problems other than at our office? If yes, please describe condition and treatment.

Please specify family members who have been treated for

Melanoma _____

Skin Cancer (Other than melanoma) _____

Lupus _____

Psoriasis _____

Eczema/ Atopic dermatitis _____

Asthma _____

Hay fever/ Seasonal allergies _____

Other skin conditions (please explain) _____

_____ Check here if you take blood thinners

_____ Check here if you take antibiotics before surgery or dental procedures

_____ Check here if you have an artificial heart valve or artificial joints

_____ Check here if you have a pacemaker or defibrillator

_____ Check here if you form thickened scars or keloids

_____ Check here if you have ever had or have hepatitis

Please list any illness for which you have been treated within the last 5 years:

Please list any prior hospitalizations and surgeries with approximate dates:

Do you smoke? _____ How frequently? _____

Do you drink? _____ How frequently? _____

Please circle YES or NO if you have been treated or are being treated for any of the following:

Heart Disease	YES	NO
Chest Pain	YES	NO
Shortness of Breath	YES	NO
Lung Disease	YES	NO
Arthritis	YES	NO
Diabetes	YES	NO
Epilepsy	YES	NO
Stomach Ulcers	YES	NO
Colitis	YES	NO
Kidney Disease	YES	NO
Liver Disease	YES	NO
Eye Disease (glaucoma)	YES	NO
Cancer	YES	NO
Blood Clots/ Strokes	YES	NO
Emotional/ Psychiatric	YES	NO
Frequent Infections	YES	NO
Thyroid Disease	YES	NO
Tuberculosis	YES	NO

Kristin Walker, M.D.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the various healthcare providers who may be involved in the treatment directly and provides who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance and companies and/ or third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by the office of their “Notice of Privacy Practices” containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such “Notice of Privacy Practices” prior to signing this consent. I understand that this office has the right to change its “Notice of Privacy Practices” from time to time, and that I may contact this organization at any time at the address below to obtain a current copy of the “Notice of Privacy Practices”.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

In addition to the above, I also consent to the following items:

- | | |
|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Allow messages to be left on my answering machine regarding my health information (i.e. test results, appointment confirmations and appointment follow-up issues) |
| <input type="checkbox"/> I do not have an answering machine | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Leave message with person who answers your phone if you are not available |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Allow appointment reminders and recall notices to be sent by postcard in the mail |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Allow appointment scheduler to verbally communicate my next appointment and/ or tests information at the checkout desk |

PATIENT NAME: _____ SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____