



Patient Information Form



Last Name		First Name & Middle Initial		
Street Address		PO Box or Apt #		
City & State	Zip Code	Home Phone	Work Phone	
Social Security #	Birth Date	Age	Sex	Cell Phone
E-mail Address	Employer		Parent / Guardian Name	
Referring Doctor		Family Doctor	Is Patient in a Hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Language:		Ethnicity: <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic Or Latino		
Race: <input type="checkbox"/> Decline to Answer <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander				
How Did You Hear About Us? <input type="checkbox"/> Friend and Family <input type="checkbox"/> Referring Doctor <input type="checkbox"/> Google or Web Search <input type="checkbox"/> Print Advertising <input type="checkbox"/> Insurance Company <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Event or Skin Cancer Screening <input type="checkbox"/> Other (Please Explain) _____ <input type="checkbox"/> Facebook or Social Media				

Release of Information

In the event that Radiant Complexions Dermatology Clinic, Iowa Dermatology Clinic PLC, or Radiant Pathology is unable to reach me by phone, I authorize the release of information regarding appointments, surgery times or pathology / lab results to:

___ I do not authorize release of information to anyone except me personally.

___ I authorize release of information regarding office appointments, surgery times and pathology/lab results to:

Name: _____ Relationship: _____ Phone Number: _____

___ I give permission to leave a message on my answering machine. ___ I give permission to contact me at the e-mail address above.

DATE: _____ SIGNATURE: _____

Authorizations

Authorization to release information: I authorize the release of any information necessary to process my insurance. I also authorize the release of any information acquired in the course of my examination or treatment to any other physician(s) involved in my case.

Authorization to Pay Benefits: (Please acknowledge and initial all three below)

I authorize my insurance to pay Iowa Dermatology Clinic PLC d/b/a Radiant Complexions Dermatology and/or Radiant Pathology directly for all medical and/or surgical charges.

I understand that it is my responsibility to understand the medical benefit provided by the insurance plan to which I subscribe.

I understand that Iowa Dermatology Clinic PLS d/b/a Radiant Complexions Dermatology Clinic and/or Radiant Pathology cannot reduce my financial responsibility for charges applied to coinsurance, copayment or deductible or any other out of pocket amounts.

Insurance Authorization

I understand that this is a lifetime signature authorization. _____ Insurance Subscriber Name _____ Date of Birth _____

DATE: _____ SIGNATURE: _____

English
Iowa Dermatology Clinic PLC d/b/a Radiant Complexions Dermatology Clinic and/or Radiant Pathology complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-204-2813.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-204-2813.



Patient Name: _____



Medical History Form

Please mark any of the following medical conditions that you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation (Irregular Heartbeat)
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Other: _____
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Acne

Date of Birth: _____

Date of Service: _____

Have you had any of the following skin conditions:

- Acne
- Actinic Keratosis
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Other: _____
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

- Do you wear sunscreen? Yes No
- Do you use tanning beds? Yes No
- Family history of melanoma? Yes No

Please list any surgeries you have had in the past:

Please list all allergies:

Please list your current medications (or provide list):

- Smoking Status? Current Former Never
- Alcohol Use? Yes No
- If yes, # of drinks/day 0 1 2 3+
- Family History of any of the following?
 - Acne Eczema Psoriasis Skin Cancer

Primary Care Provider Name: _____

Preferred Pharmacy: _____

Pharmacy Location: _____

Reason for Visit Today: _____

Please mark any condition below that you are currently experiencing:

- | | | | | |
|--|---|---|--|--|
| Skin
<input type="checkbox"/> Rash
<input type="checkbox"/> Dry Skin
<input type="checkbox"/> Itching
<input type="checkbox"/> Change in Mole(s)
<input type="checkbox"/> Hives
<input type="checkbox"/> Open Wound
<input type="checkbox"/> Wart
<input type="checkbox"/> Eczema
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Cyst
<input type="checkbox"/> Problems w/ Healing
<input type="checkbox"/> Problems w/ Scarring
<input type="checkbox"/> Problems w/ Bleeding
<input type="checkbox"/> Acne | Constitutional
<input type="checkbox"/> Fever
<input type="checkbox"/> Chills
<input type="checkbox"/> Runny Nose

Endocrine
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Problems

Musculoskeletal
<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Joint Aches | ENMT
<input type="checkbox"/> Sore Throat

Eyes
<input type="checkbox"/> Blurry Vision

Neuro
<input type="checkbox"/> Headaches
<input type="checkbox"/> Seizures | GI
<input type="checkbox"/> Nausea
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Abdominal Pain

Cardiovascular
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Light Headed

Psych
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety | GU
<input type="checkbox"/> Difficult Urination
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Incontinence

Respiratory
<input type="checkbox"/> Cough
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Wheezing

Hem/Lymph
<input type="checkbox"/> Tender lymph nodes |
|--|---|---|--|--|

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Patient Privacy Information Form

SUMMARY OF PRIVACY PRACTICES & PATIENT ACKNOWLEDGEMENT FORM

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. The full version is available at our front desk. Copies can be made as requested.

Date of Last Revision: August 12, 2015
Effective Date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- For workers' compensation programs

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

I am a patient of Iowa Dermatology Clinic, PLC; Radiant Complexions Dermatology Clinic or Radiant Pathology. I hereby acknowledge receipt of this Notice of Privacy Practices.

Signature: _____

Patient's Name: _____

Date: _____ Relationship to Patient (if patient is under 18 years old): _____

If patient refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

Signature (name and title): _____

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