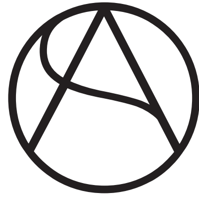

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DERMATOLOGY PATIENT QUESTIONNAIRE

To help us provide you with the best possible care, please fill out all the information listed below.

Patient Name:____

Name of physician who requested consultation: ______________________________

Reason for visit today	
Please describe your skin problem: (e.g. rash, “bump”, sore, symptom, etc)	
Where is it located on your body?	
How long has it been there?	
Is your problem mild, moderate, or severe?	
How does it feel? (e.g. itching, burning, painful, no symptoms at all, etc)	
What, if anything, is making your problem BETTER?	
What, if anything, is making your problem WORSE?	
What treatment have you tried? (List prescriptions, over-the-counter products, procedures etc.)	
Results: Check appropriate answer	Not applicable Resolved Improved Unchanged Worse

Patient Name:______________________________

PREFERRED PHARMACY

Please fill out address and phone number.

Pharmacy Name:
Pharmacy Address:
City/State/Zip Code:
Phone Number:

PAST MEDICAL HISTORY

(Please list all CURRENT medical conditions)

PAST SURGICAL HISTORY

Year	Procedure/Surgery	Year	Procedure/Surgery

For Pediatric Patients:

Gestational age: __________________ weeks

Birth Weight ____________________________

Complications during pregnancy? ____

Patient Name:________________________________

PATIENT SKIN CANCER HISTORY

TYPE	LOCATION	YEAR	TREATMENT
Basal Cell Carcinoma			
Squamous Cell Carcinoma			
Melanoma			

Abnormal Moles: ○ Yes ○ No If yes, where? ____________________

Have you had any blistering sunburns? ○ Yes ○ No

Do you wear sunscreen? ○ Yes ○ No

Do you have a **family history** of melanoma? ○ Yes ○ No

If yes, which relative(s): ____________________

Do you have a **family history** of Squamous Cell Carcinoma? ○ Yes ○ No

If yes, which relative(s): ____________________

Do you have a **family history** of Basal Cell Carcinoma? ○ Yes ○ No

If yes, which relative(s): ____________________

CURRENT MEDICATIONS

(Please list all medications including skin medications)

NAME	DOSE	HOW OFTEN	START DATE (month/year)

Patient Name:________________________________

MEDICATION ALLERGIES/REACTIONS

(List all allergies to any medication and the reactions)

○ **No Known Drug Allergies**

MEDICATION	REACTION

SOCIAL HISTORY

	STATUS		HOW OFTEN?		
Do you smoke?	○ YES	○ NO	○ Previous smoker	○ 1 pack/day	○ 2+ pack/day
Do you consume alcohol?	○ YES	○ NO	○ 1</per day	○ 1-2/per day	○ 3+ pack/day
Do you exercise?	○ YES	○ NO	○ Never	○ Daily	○ Weekly
Do you consume caffeine?	○ YES	○ NO	○ Never	○ Daily	○ Weekly

For Pediatric Patients:

What grade is patient in? ________________

Does the patient go to daycare? ○ Yes ○ No

Are there pets in the home? ○ Yes ○ No If Yes, What type of pet? ____________________

Who lives in the house? ____

Parent/Guardian Names____

Patient Name:________________________________

REVIEW OF SYMPTOMS

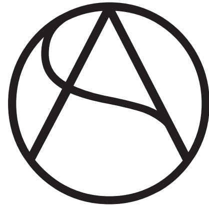
Symptom	YES	NO	Symptom	YES	NO
Problems with bleeding	YES	NO	Abdominal Pain	YES	NO
Problems with healing	YES	NO	Bloody Stool	YES	NO
Problems with scarring (Hypertrophic or Keloid)	YES	NO	Bloody Urine	YES	NO
Rash	YES	NO	Joint Aches	YES	NO
Immunosuppression	YES	NO	Muscle Weakness	YES	NO
Hay Fever	YES	NO	Neck Stiffness	YES	NO
Fever	YES	NO	Headaches	YES	NO
Chills	YES	NO	Seizures	YES	NO
Night Sweats	YES	NO	Cough	YES	NO
Unintentional Weight Loss	YES	NO	Shortness of Breath	YES	NO
Thyroid Problems	YES	NO	Wheezing	YES	NO
Sore Throat	YES	NO	Anxiety	YES	NO
Blurry Vision	YES	NO	Depression	YES	NO

DO YOU HAVE?

Item	YES	NO	Item	YES	NO
Allergy to adhesive	YES	NO	MRSA	YES	NO
Allergy to Lidocaine	YES	NO	Pacemaker	YES	NO
Allergy to Topical Antibiotic	YES	NO	Premedication prior to procedure	YES	NO
Artificial Heart Valve	YES	NO	Pregnant	YES	NO
Artificial joint within 2 years	YES	NO	Planning a pregnancy	YES	NO
Blood Thinners	YES	NO	Rapid Heartbeat with Epinephrine	YES	NO
Defibrillator	YES	NO	Other:	YES	NO

FAMILY HISTORY

Condition	YES	NO	If yes, please list family member:
Asthma	YES	NO	
Allergies	YES	NO	
Atopic Dermatitis	YES	NO	
Depression	YES	NO	
Cancer and Type	YES	NO	
Psoriasis	YES	NO	
Autoimmune Disease	YES	NO	
Other	YES	NO	
Other	YES	NO	
Other	YES	NO	
Other	YES	NO	



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PATIENT INFORMATION

(Please Print – Fill in All Blanks)

Patient's Legal Name: Last First M.I.	Sex:	DOB:	Age:

Social Security Number:	Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated
Patient's Address:	Employment Status: ◯ Employed ◯ Full-time student ◯ Part-time student ◯ Retired
City: / State: / Zip Code:	Referring Physician:
Home Phone: / Work Phone:	Cell Phone: / E-mail

Ethnicity:	Race:	Preferred Language:

INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim.

Name of Primary Insurance Company	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	
Secondary Insurance (if applicable)	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	

EMPLOYMENT INFORMATION

Patient's Employer	Phone Number
Insured Employer	Phone Number

If the patient is a minor, please list both parent names and employers

Mother	DOB	Employer	Phone Number
Father	DOB	Employer	Phone Number

NEXT-OF-KIN INFORMATION

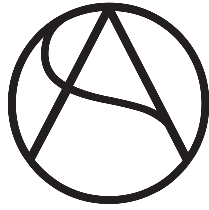
Nearest relative (or friend, not spouse), not living with you:	
Home Phone:	Relationship to Patient:

THIRD PARTY BILLING (circle one)

Is your injury work related?	YES ◯	NO ◯
Is this injury due to an accident?	YES ◯	NO ◯
If your injury is MVA related, have you obtained an accident report?	YES ◯	NO ◯

I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG Privacy Notice.

Signature:	Date:



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AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Skin Associates/The Physicians' Group (TPG) to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Skin Associates/The Physicians' Group (TPG) to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Oklahoma Skin Associates/The Physicians' Group (TPG) charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Skin Associates/The Physicians' Group (TPG) , its agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Oklahoma Skin Associates/The Physicians' Group (TPG). I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Skin Associates/The Physicians' Group (TPG) from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

Signed ___________________________________ Date ___________________________
(Patient)

OR ___________________________________
(Nearest relative or responsible party)

______________________________________ Policyholder's Signature _________________________
(Relationship to patient)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

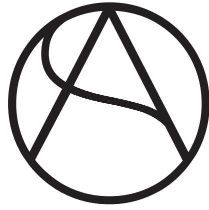

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Chart No. ______________

Authorization to Release Information via Phone/Family/Friends

Patient Name:____ DOB:______________

I hereby authorize confidential communications from the physicians or staff of Oklahoma Skin Associates/The Physicians' Group (TPG) regarding my health, care, treatments, appointments, prescriptions, etc…to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home Phone		Work Phone	
Cell Phone		Other	

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plans, medications and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

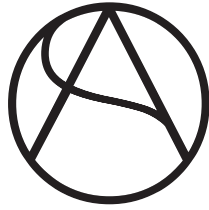
Name		Relation	
Name		Relation	
Name		Relation	
Name		Relation	

I understand that this authorization will remain in effect until I revoke the authorization in writing.

____ ________________________
Patient Signature Date

STAFF ONLY

Documented by: Initials _______ Date _______



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FINANCIAL POLICY

Thank you for choosing Oklahoma Skin Associates/The Physicians' Group (TPG) are you healthcare provider. At Oklahoma Skin Associates/The Physicians' Group (TPG), we are dedicated to providing the highest quality, most cost effective care.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring your current insurance card, or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 405.427.3705 to make financial arrangements.

There is a $35 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion. There is a $50.00 charge for any appointments not cancelled within 24 hours.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing Oklahoma Skin Associates/The Physicians' Group (TPG) to participate in your care.

Sincerely,

Oklahoma Skin Associates/The Physicians' Group (TPG) and Staff

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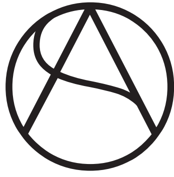
My signature below acknowledges receipt of this Financial Policy:

Signed____ Date_______________
(Signature of person financially responsible for payment)

Relationship if other than patient____



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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how Oklahoma Skin Associates/The Physicians' Group, LLC or HPI Physicians, LLC, as applicable (the "Practice"), will use protected health information for the purposes of treatment, payment for treatment and healthcare operations.
- The Notice explains in more detail how the Practice may use and share protected health information other than treatment, payment and healthcare operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient Name (print): ____

Patient Date of Birth: ____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:

____

____

____ Date:________________________

Signature of Patient or Patient's Personal Representative

Current contact information for patient or personal representative signing this form:

Name (print): ____

Address: ____

Telephone: ____

E-mail: ____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgement but did not because:

_____ It was emergency treatment
_____ I could not communicate with the patient
_____ The patient refused to sign
_____ The patient was unable to sign because ______________________________
_____ Other: ____

Signature Practice Staff Member	Name (please print) and title	Date

This form should be placed in patient's medical record.