

# SCHOLES DERMATOLOGY

## HIPAA REGISTRATION FORM Release of Information

Full Name \_\_\_\_\_ Gender- Male \_\_\_\_\_ Female \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell# \_\_\_\_\_  
SSN \_\_\_\_\_ Email \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
Place of Employment/Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

**May we leave medical information about you on your answering machine? Yes or No**

**May we discuss your medical information with anyone other than you? Yes or No**

**Names of family Members:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Insurance Policy Holder or Responsible Party Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address if different than above: \_\_\_\_\_

### **PRIMARY CARE PROVIDER:**

Were you referred to our office? Yes or No

If yes, Physicians Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

In order to provide you with the best patient care possible, your doctor may discuss your case or transfer all or part of your medical records to a consulting physician or your referring physician. Your signature also authorizes Scholes Dermatology to release carrier information regarding care to your insurance company for the purpose of billing.



Scholes Dermatology, LLC  
526 Shoup Ave W, Suite A  
Twin Falls, ID 83301  
208-734-5555

## Consent for Treatment, Financial Agreement, and Records Release

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

I, the undersigned as the patient (or authorized person), consent to any treatment and/or procedures rendered to me that may, under the judgement and instruction of the treating provider, be considered advisable or necessary. I understand that if any extensive procedure or surgery is to be procedure or surgery is to be performed, it will be fully explained to me, including the risks, benefits and alternatives, and my specific consent will be necessary. I voluntary give my consent for treatment and also my consent to any procedure that my provider performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injections of skin lesions, cauterizations of skin lesions, surgery /electro cautery.

**Initial** \_\_\_\_\_

I understand that any ancillary services (x-rays, lab tests, pathology, slide prep etc.) that may be ordered be ordered by the medical provider while I am in the clinic are not included in my clinic bill and that I will be billed separately for those services.

In addition, I authorized **Scholes Dermatology, LLC** , along with any contracted provider or outside provider to furnish all medical and financial information related to for this visit to my insurance carrier and/or any agency working on their behalf. I hereby authorize payment of benefits on my behalf to any of the providers performing services related to this encounter. I understand that certain services may not be covered or may be denied by my insurance carrier and I hereby guarantee payment of the charges incurred and agree to pay any unpaid balances.

I, the undersigned, have read the above authorizations and understand the same and certify that no guarantees or assurances have been made as to the results or outcome of any treatment procedure or diagnosis.

\_\_\_\_\_  
**Signature or Patient or legal Representative**

\_\_\_\_\_  
**Date**

## Scholes Dermatology- Medical History

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

**Medical History:** Do you now have (or have had in the past) and the following conditions? Please check all that apply:

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li><input type="radio"/> Anxiety</li> <li><input type="radio"/> Arthritis (Osteo)</li> <li><input type="radio"/> Arthritis (RA)</li> <li><input type="radio"/> Asthma</li> <li><input type="radio"/> Atrial Fibrillation/ Irregular Heartbeat</li> <li><input type="radio"/> Benign prostatic hyperplasia</li> <li><input type="radio"/> Coronary arteriosclerosis (Heart Disease)</li> <li><input type="radio"/> COPD</li> <li><input type="radio"/> Depression</li> <li><input type="radio"/> Diabetes</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> End stage renal disease</li> <li><input type="radio"/> Epilepsy</li> <li><input type="radio"/> Gastric Reflux (GERD)</li> <li><input type="radio"/> Hypertenion</li> <li><input type="radio"/> Hearing Loss</li> <li><input type="radio"/> Hepatitis Type _____</li> <li><input type="radio"/> HIV/AIDS</li> <li><input type="radio"/> High Cholesterol</li> <li><input type="radio"/> Leukemia</li> <li><input type="radio"/> Lymphoma</li> <li><input type="radio"/> Lung Cancer</li> <li><input type="radio"/> Breast Cancer</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Colon Cancer</li> <li><input type="radio"/> Prostate Cancer</li> <li><input type="radio"/> Radiation Treatment</li> <li><input type="radio"/> Seizures</li> <li><input type="radio"/> Stroke</li> <li><input type="radio"/> Thyroid</li> <li><input type="radio"/> Transplant of bone marrow</li> <li><input type="radio"/> Other disease not listed</li> </ul> |
|---|---|--|

**Surgical History:** Please check all that apply to you:

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li><input type="radio"/> No Previous Surgeries</li> <li><input type="radio"/> Appendix</li> <li><input type="radio"/> Bladder Removal</li> <li><input type="radio"/> Breast Biopsy</li> <li><input type="radio"/> Breast Lumpectomy (Left)</li> <li><input type="radio"/> Breast Lumpectomy (Right)</li> <li><input type="radio"/> Breast Mastectomy (Left)</li> <li><input type="radio"/> Breast Mastectomy (Right)</li> <li><input type="radio"/> Colon Surgery (Cancer)</li> <li><input type="radio"/> Colon Surgery (Diverticulitis)</li> <li><input type="radio"/> Colon Surgery (UC/Crohn)</li> <li><input type="radio"/> Gall Badder</li> <li><input type="radio"/> Heart Bypass (CABG)</li> <li><input type="radio"/> Heart Stent</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Heart Transplant</li> <li><input type="radio"/> Heart Valve (Mechanical)</li> <li><input type="radio"/> Heart Valve (biological)</li> <li><input type="radio"/> Heart: PTCA</li> <li><input type="radio"/> Hip Replacement (Left)</li> <li><input type="radio"/> Hip Replacement (Right)</li> <li><input type="radio"/> Knee Replacement (Left)</li> <li><input type="radio"/> Knce Replacement (Right)</li> <li><input type="radio"/> Kidney Biopsy</li> <li><input type="radio"/> Kidney Transplant</li> <li><input type="radio"/> Liver Transplant</li> <li><input type="radio"/> Liver Shunt</li> <li><input type="radio"/> Prostate Biopsy</li> <li><input type="radio"/> Prostate Cancer</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Prostate TURP</li> <li><input type="radio"/> Oophorectomy</li> <li><input type="radio"/> Rectum Resection</li> <li><input type="radio"/> Skin Biopsy</li> <li><input type="radio"/> Melanoma</li> <li><input type="radio"/> Spleen (Splenectomy)</li> <li><input type="radio"/> Testicles (Orchiectomy)</li> <li><input type="radio"/> Hysterectomy (Fibroids)</li> <li><input type="radio"/> Hysterectomy (Uterine Cancer)</li> <li><input type="radio"/> Hysterectomy (Cervical Cancer)</li> <li><input type="radio"/> Other surgeries not listed</li> </ul> |
|--|--|---|

**Skin Disease History:** Please check all that apply to you:

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li><input type="radio"/> Acne</li> <li><input type="radio"/> Actinic Keratoses</li> <li><input type="radio"/> Posion Ivy</li> <li><input type="radio"/> Dry Skin</li> <li><input type="radio"/> Eczema</li> <li><input type="radio"/> Flaking or Itchy Scalp</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Hay fever/ Allergies</li> <li><input type="radio"/> Asthma</li> <li><input type="radio"/> Melanoma</li> <li><input type="radio"/> Psoriasis</li> <li><input type="radio"/> BCC-<br/>Where? _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> SCC-<br/>Where? _____</li> <li><input type="radio"/> Sunburn of second degree (Blisters)</li> </ul> |
|---|--|--|
- Other skin problems not listed: \_\_\_\_\_

Do you wear sunscreen? Yes No What SPF? \_\_\_\_\_

Do you tan in a tanning salon? Yes No

Do you have a family history of Skin Cancer?

Who? \_\_\_\_\_

Does anyone in your family have a history of Melanoma?

Who? \_\_\_\_\_

Do you get your flu shot year? Yes No

If over 66- Have you had your Pnemonia Vaccine? Yes No

Do you have a living Will? YES NO

Do you have a health care proxy in the event you are unable to make your own medical decisions? YES NO

**Current Medications:** Check here \_\_\_\_\_ if you take no medications.

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medications:** Please list any medications to which you are allergic: NONE

\_\_\_\_\_  
\_\_\_\_\_

Which pharmacy do you use? \_\_\_\_\_ City \_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_

**PRIMARY DOCTOR:** \_\_\_\_\_

**Smoking History:** Please check one of the following:

- Never smoked
- Current every day smoker- Cigarettes/ E-Cig/Vape
- Chewing Tobacco
- Current occasional smoker
- Former smoker

**Alcohol history:** Please check one of the following:

- None
- Less than one drink per day
- 1-2 drinks per day
- 3 or more drinks per day

**Female Patients:**

Are you pregnant? Yes No Due date: \_\_\_\_\_

Are you breast-feeding Yes No