Robert C. Griffith, MD

Dermatology

Patient name: ______________________D.O.B. ___________________

Do you wear sunscreen? Yes/No If yes, what SPF? ___________________
Do you use a tanning bed? Yes/No If yes, how often? _________________
Do you have a family history of melanoma? Yes /No If yes, which relative? _______________
Do you have a family member with asthma, lung disease, or allergies? Yes/No If yes, which relative? _______________

Medications: List all current medications including vitamins and supplements (include strength and frequency)		

Allergies: Please list all medication, environmental, and food allergies and type of reaction(s)

Smoking Status	Social History: Please select all that apply.	
☐ Current every day smoker	☐ Not sexually active	☐ Drug Use
☐ Current some day smoker	☐ Sexually active with one partner	☐ IV drug use
☐ Former smoker	☐ Sexually active with >1 partner	☐ Alcohol use: none
☐ Never smoker	☐ Same gender sex partner	☐ Alcohol use: <1 drink per day
Caffeine Use	**How often do you exercise?**	☐ Alcohol use: 1-2 drinks per day
☐ Several times per day	☐ Several times per day	☐ Alcohol use: 3 or more per day
☐ Once a day	☐ Once a day	☐ Patient feels safe at home
☐ A few times a day	☐ A few times a week	☐ Patient doesn’t feel safe at home
☐ A few times a month	☐ A few times a month	☐ Patient drives during daytime
☐ Never	☐ Never	☐ Patient drives at night

Occupation and workplace: ____

Robert C. Griffith, MD
Dermatology

Patient name: ______________________D.O.B. ___________________

Symptom	Yes	No
Problems with bleeding	☐	☐
Problems with healing	☐	☐
Problems with scarring	☐	☐
Rash	☐	☐
Immunosuppression	☐	☐
Hay fever	☐	☐
Chest pain	☐	☐
Fever or chills	☐	☐
Night sweats	☐	☐
Unintentional weight loss	☐	☐
Thyroid problems	☐	☐
Sore throat	☐	☐
Blurry vision	☐	☐
Abdominal pain	☐	☐
Bloody stool	☐	☐
Bloody urine	☐	☐
Joint aches	☐	☐
Muscle weakness	☐	☐
Neck stiffness	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Alerts	Yes	No
Medication Allergy	☐	☐
Allergy to adhesive	☐	☐
Allergy to lidocaine	☐	☐
Allergy to topical antibiotics	☐	☐
Artificial heart valve	☐	☐
Artificial joint with in last 2 years	☐	☐
Blood thinners	☐	☐
Defibrillator	☐	☐
MRSA	☐	☐
Pacemaker	☐	☐
Premed prior to procedure	☐	☐
Rapid heartbeat with epinephrine	☐	☐
Pregnant or planning pregnancy	☐	☐
Fainting	☐	☐

Additional Practice / Patient Data
Preferred Pharmacy:
Pharmacy Phone #:
Country of Birth:
Birth Sex:

Patient Vitals:	
Height:	Ft:
	In:
Weight:	Lb:
	Oz:

B/P:	
Pulse:	
O2%:	
Temp:	

Patient/Parent/Guardian: ____

Reviewed by: ____

Annual Renew Date: ___/___/_____ Annual Renew Date: ___/___/_____ Annual Renew Date: ___/___/_____

History and Intake Form

Robert C. Griffith, MD
Dermatology

Patient name: ______________________D.O.B. ___________________

Past Medical History: Have you ever had or currently have? Check here if none _______			
☐ Anxiety	☐ Coronary Artery Disease	☐ High Cholesterol	☐ Stroke
☐ Arthritis	☐ Depression	☐ Hyperthyroidism	☐ Irritable Bowel Syndrome
☐ Asthma	☐ Diabetes	☐ Hypothyroidism	☐ Multiple Sclerosis
☐ Atrial Fibrillation	☐ End Stage Renal Disease	☐ Leukemia *	☐ Congestive Heart Failure
☐ Fainting	☐ GERD	☐ Lymphoma *	☐ Bleeding Disorder
☐ Breast Cancer *	☐ Hearing Loss	☐ Lung Cancer*	☐ Lupus
☐ Colon Cancer *	☐ Prostate Cancer *	☐ Hepatitis A/B/C *	☐ HIV/AIDS
☐ Rheumatoid Arthritis	☐ High Blood Pressure	☐ Radiation Treatment	☐ Bone Marrow Transplant
☐ COPD	☐ Seizures	☐ Tuberculosis	☐

*Provide date of diagnosis and any additional information

Past Surgical History: Have you ever had? Check here if none _____			
☐ Appendix removed	☐ Gallbladder removed	☐ Kidney removed (R / L)	☐ Spleen removed
☐ Bladder removed	☐ Heart Bypass	☐ Kidney stone removed	☐ Testicles removed (R / L)
☐ Mastectomy (R / L)	☐ Angioplasty	☐ Kidney transplant	☐ Hysterectomy
☐ Breast Lump (R / L)	☐ Heart Valve Replacement	☐ Ovaries removed	☐ Kidney Biopsy
☐ Breast Biopsy (R / L)	☐ Heart Transplant	☐ Prostate biopsy	☐ Colon removed
☐ Breast reduction	☐ Knee Replacement (R / L)	☐ Prostate removed	☐
☐ Breast implants	☐ Hip Replacement (R / L)	☐ Skin biopsy	☐

Skin Disease History: Have you ever had or currently have? Check here if none _______			
☐ Acne	☐ Blistering Sunburns	☐ Hay Fever/ Allergies	☐ Psoriasis
☐ Actinic keratoses	☐ Dry skin	☐ Melanoma*	☐ Squamous cell cancer*
☐ Asthma	☐ Eczema	☐ Poison Ivy	☐ Keloids
☐ Basal Cell Cancer *	☐ Itchy/Flaky Scalp	☐ Precancerous/ Abnormal Moles	☐ Fever Blisters (Herpes)

*Provide date of diagnosis and any additional information

MR#: ____________________

MR# to be entered by the practice

Robert C. Griffith M.D.
Dermatology

Date Completed:	

PATIENT INFORMATION

Patient Name			SSN#	Birthdate	Gender
First	M.I.	Last			☐ Male ☐ Female

Mailing Address

Street	City	State	Zip

Primary Phone	Secondary Phone	Email Address

Employer Name	Occupation	Work Phone

Marital Status	Student Status	Veteran?
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	☐ N/A ☐ Full-Time ☐ Part-Time	☐ Yes ☐ No

Race	Ethnicity	Primary Language
☐ White ☐ African American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Other ________________________ ☐ Prefer Not to Report	☐ Hispanic ☐ Non-Hispanic ☐ Prefer Not to Report	☐ English ☐ Spanish ☐ Prefer Not to Report ☐ Other ___________

LEGAL GUARDIAN

If patient is a minor or requires a guardian, provide the information requested below; otherwise leave blank

First	M.I.	Last	Relationship	Primary Phone	Secondary Phone

RESPONSIBLE PARTY/GUARANTOR INFORMATION

If guarantor (individual responsible for fees not paid by insurance) is not the patient, provide information below; otherwise mark "SAME AS PATIENT"

Guarantor Name ☐ SAME AS PATIENT			Primary Phone	Secondary Phone	Relationship to Patient
First	M.I.	Last			

Mailing Address

Street	City	State	Zip

INSURANCE INFORMATION

If insurance policy holder is different from patient, provide policy holder information; otherwise mark "SAME AS PATIENT" for policy holder name

PRIMARY	Insurance Company Name	Insurance Plan Name (if known)		Insurance Plan/Group ID (if known)
	Policy Holder Name ☐ SAME AS PATIENT	Birthdate	SSN#	Relationship to Patient
	Policy Holder's Address			Policy Holder's Phone
SECONDARY	Insurance Company Name	Insurance Plan Name (if known)		Insurance Plan/Group ID (if known)
	Policy Holder Name ☐ SAME AS PATIENT	Birthdate	SSN#	Relationship to Patient
	Policy Holder's Address			Policy Holder's Phone

CARE TEAM INFORMATION

Primary Care Physician	Referring Provider (i.e. who sent you to our office?)

MR#: ____________________

PATIENT REGISTRATION AGREEMENT AND CONSENTS

1. CONSENT TO MEDICAL CARE AND TREATMENT

The below-signed individual hereby authorizes Robert C. Griffith M.D. (the Practice) and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees.

There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees the Practice and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

2. EMERGENCY CONTACT

In the event of an emergency, I authorize the Practice to contact the individual identified below:

Name	Relation to Patient	Phone

3. VOICEMAIL AUTHORIZATION

If Practice is unable to contact me directly, Practice may leave information related to my treatment/diagnostic test results and information about my appointments with any voicemail system that answers at my designated phone numbers (primary and secondary).

4. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and as authorized or permitted by federal or state law.

Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

5. PATIENT IDENTIFICATION

The undersigned acknowledges the Practice may request to take a photograph of me or specimen sites for the sole purpose of patient identification and diagnostic testing. I consent to the taking of my photograph for this purpose. I understand that the photograph will be maintained in a secure manner and will not be released except upon written authorization from me or my authorized representative or as required or permitted by law.

6. PERSONAL PROPERTY AND VALUABLES

The undersigned agrees that the Practice is not responsible for loss, theft, or damage of any money, personal property, or other valuables.

7. CONSENT TO COMMUNICABLE DISEASE TESTING

The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

8. CALCULATION AND PAYMENT OF CHARGES

The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following:

a. The patient is liable for the uninsured portion of the Practice bill. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient or designated guarantor.
b. Any specimens (e.g. blood, urine, or biopsy) collected for tests not performed by the Practice's lab may be sent to hospitals or outside laboratories. Insurance information is provided to such outside entities for billing the patient and/or their insurer for these services.
c. The undersigned acknowledges receipt of the Practice's Payment Policies, which is incorporated into this Agreement by reference, and understands the Practice may charge a "no show" or "late cancellation" fee to any patient that fails to show up (no shows) for their appointment or cancels their appointment with less than twenty four (24) hours of notice. The Practice reserves the right to modify its payment policies at any time and will make every reasonable effort to inform the patient (e.g. posted at check-in/check-out desks, posted on web site, etc.) of these changes; however, the patient agrees to abide by the Practice Payment Policies if they are receiving services from the Practice.
d. After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

9. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS

The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice billing such payers for items and services furnished by the Practice. The undersigned hereby irrevocably assigns to Practice all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to Practice all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section 7 (CALCULATION AND PAYMENT OF CHARGES) or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers do not pay. Any sums not paid by a third-party payer are the patient's obligation. The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as non-covered or excluded items or services. If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

10. HEALTH PLAN NOTIFICATION/AUTHORIZATION

If the patient's health plan, insurer, or other coverage requires prior authorization or precertification as a condition of payment for services, the patient must provide such documentation or notify the practice prior to services being performed. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Also, the patient hereby appoints the Practice as the patient's agent for purposes of requesting prior authorization and precertification for services (e.g. lab services). The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

11. AMENDMENTS

Revisions to this Agreement are not effective or enforceable unless accepted in writing by an authorized agent of the Practice.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

________________________________	________________________	
Signature of Patient or Legal Representative	Date	
Printed Name	Patient Name (if signed by representative)	Relationship to Patient