Dear New Patient:

**Welcome to our Practice!** Thank you for allowing us to serve your health care needs. The following information is provided to introduce you to our practice and our practice policies.

Please complete the forms and bring them with you to your first appointment to help speed up the check in process. You will need to arrive 15 minutes prior to your appointment time, so that we may get all your paperwork together and set up your chart to be ready for your appointment time.

If you have medical insurance, please bring all of your current insurance identification cards with you to the appointment. **We recommend that you contact your insurance company prior to your appointment to verify that our office is contracted with your particular health plan.** You may do this by calling the (800) telephone number on the back of your card and giving them our Tax ID# 73-1724449. Please check to make sure that your cards are not expired. You will also need to bring a valid photo identification card to be seen in our office.

It is necessary for you to bring any copayments, coinsurance and or deductible monies you will owe, according to your insurance benefits, to your office visit and it will be collected at the time of check in. For self pay patients, payment in full at the time of service is required. **No Checks Are Accepted.**

Thank You! We look forward to meeting you soon.

Dr. Dyan Harvey-Dent

Medical Director

Unique Dermatology & Wellness Center
### PATIENT INFORMATION (Please Print)

Name: ____________________________________________________________ Today’s Date: ___ / ___ / ___

Last First MI

Preferred Name: ___________________________ Drivers License #: ________________________________

Date of Birth: ____________________ Social Security #: ________________________________ Gender: Male or Female

Marital Status: Single / Married / Divorced / Separated / Widow

Address:__________________________________________________________

Street                                                                   City

State               Zip Code

Home Phone: (___)_________________________ Cell Phone: (___)_________________________ Work Phone: (___)_________________________

Preferred Method of Contact (Please circle one): Home Phone Cell Phone Work Phone Email

Is it OK to leave a detailed message on your voice mail? Yes or No

Personal Email Address: ________________________________

☐ Please add my email address to your mailing list to receive e-mail updates/ specials

Preferred Language (Please circle one): English Spanish Other: _____________________________

Race (Please circle one): American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White/ Caucasian Unknown

Ethnicity (Please circle one): Hispanic of Latino Not Hispanic or Latino Decline to specify

### EMPLOYMENT INFORMATION

Employment Status: Employed Student Self-employed Retired

Employer’s Name: _____________________________ Occupation: _____________________________

### EMERGENCY CONTACT INFORMATION

Emergency Contact: _____________________________ Relationship: _____________________________

Phone #1: (___)_________________________ Phone#2: (___)_________________________

Would you like your medical information released to any family member? Yes No

If yes, whom? _____________________________ Relationship to you: _____________________________ Phone#: ______

### HOW DID YOU HEAR ABOUT US?

Physician / Family / Friend / Yellow Pages/ Insurance Carrier/ Internet / Newspaper Ad/ Exterior Signage Other: _____________________________
PRIMARY CARE PHYSICIAN

Name: ____________________________________ Practice Name: ______________________________

INSURANCE INFORMATION:  (Please present your current insurance card at time of check in).

Primary Insurance: ______________________________  Secondary Insurance: ______________________________
Policy ID#: ______________________________  Policy ID#: ______________________________
Group #: ______________________________  Group #: ______________________________
Insurance Phone #: ______________________________  Insurance Phone #: ______________________________
Policy Holder (if not patient): ______________________________  Policy Holder (if not patient): ______________________________
Policy Holder SSN: ______________________________  Policy Holder SSN: ______________________________
Policy Holder Date of Birth: ______________________________  Policy Holder Date of Birth: ______________________________

I understand that I am responsible for all fees regardless of insurance coverage, and that charges are due at time of service unless other arrangements have been made in advance of treatment. If Unique Dermatology & Wellness Center does bill my insurance, I authorize them to release any or all of my medical records to my insurance companies for assigned payment of medical benefits. I also understand that I will be billed separately by the laboratory for any lab tests that are sent out for testing. Consent is hereby given to the treating physician to administer treatment and to perform such medical and/or surgical procedures that are deemed necessary for treatment.

Patient (Print Name): ______________________________  Date: ______________________________

Patient (Signature): ______________________________
**PATIENT MEDICAL HISTORY**

**PATIENT NAME:** ___________________________________  **DATE:** __________________

**REASON FOR VISIT:** ____________________________________________________________

**PHARMACY NAME:** ___________________________________  **PHONE #:** ___________

**PHARMACY ADDRESS:** _________________________________________________________

**Past Medical History:** (Please circle all that apply)

<table>
<thead>
<tr>
<th>NONE</th>
<th>COPD</th>
<th>High Cholesterol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Coronary Artery Disease</td>
<td>Hyperthyroidism</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Depression</td>
<td>Hyperthyroidism</td>
</tr>
<tr>
<td>Asthma</td>
<td>Diabetes</td>
<td>Leukemia</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>End Stage Renal Disease</td>
<td>Lung Cancer</td>
</tr>
<tr>
<td>Bone Marrow Transplantation</td>
<td>GERD (reflux)</td>
<td>Lymphoma</td>
</tr>
<tr>
<td>BPH (enlarged prostate)</td>
<td>Hearing Loss</td>
<td>Prostate Cancer</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Hypertension</td>
<td>Radiation Treatment</td>
</tr>
<tr>
<td>Colon Cancer</td>
<td>HIV/AIDS</td>
<td>Stroke</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Past Surgical History:** (Please circle all that apply)

<table>
<thead>
<tr>
<th>NONE</th>
<th>Heart Transplant</th>
<th>Prostate Removed: Prostate Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix Removed</td>
<td>Heart: Mechanical Valve Replacement</td>
<td>Prostate Biopsy</td>
</tr>
<tr>
<td>Bladder Removed</td>
<td>Heart: Angioplasty/Stent</td>
<td>TURP (Prostate Removed)</td>
</tr>
<tr>
<td>Breast Biopsy</td>
<td>Joint Replacement: Hip Rt/Lf/Both</td>
<td>Skin Cancer Surgery: Basal, Squamous, Melanoma</td>
</tr>
<tr>
<td>Breast: Lumpectomy- Rt/Lf/Both</td>
<td>Kidney Biopsy</td>
<td>Spleen Removed</td>
</tr>
<tr>
<td>Breast: Mastectomy -Rt/ Lf/ Both</td>
<td>Kidney Stone Removal</td>
<td>Testicles Removed</td>
</tr>
<tr>
<td>Breast Implants</td>
<td>Kidney Transplan t</td>
<td>Hysterectomy: Fibroids</td>
</tr>
<tr>
<td>Colectomy: Colon Cancer Resection</td>
<td>Kidney Removed</td>
<td>Hysterectomy: Uterine Cancer</td>
</tr>
<tr>
<td>Colectomy: Diverticulitis</td>
<td>Liver Transplant</td>
<td>Hysterectomy: Cervical Cancer</td>
</tr>
<tr>
<td>Colectomy: IBD</td>
<td>Ovaries Transplant</td>
<td>Ovaries Removed: Endometriosis</td>
</tr>
<tr>
<td>Gallbladder Removed</td>
<td>Ovaries Removed: Ovarian Cancer</td>
<td></td>
</tr>
<tr>
<td>Heart: Biological Valve Replacement</td>
<td>Ovaries Removed: Ovarian Cyst</td>
<td></td>
</tr>
<tr>
<td>Heart: Coronary Artery Bypass</td>
<td>Ovary: Tubal Ligation</td>
<td></td>
</tr>
</tbody>
</table>
**Skin Disease History:** (Please circle all that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>None</th>
<th>Dry Skin</th>
<th>Precancerous Moles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td></td>
<td>Eczema</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Actinic Keratosis</td>
<td></td>
<td>Flaking or Itchy Scalp</td>
<td>Squamous Cell Skin Cancer</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Hay Fever/ Allergies</td>
<td></td>
</tr>
<tr>
<td>Basal Cell Skin Cancer</td>
<td></td>
<td>Melanoma</td>
<td>Other:</td>
</tr>
<tr>
<td>Blistering Sunburns</td>
<td></td>
<td>Poison Ivy</td>
<td></td>
</tr>
</tbody>
</table>

Do you wear sunscreen?  
Yes  
No  
If yes, what SPF? __________

Do you tan in a tanning salon?  
Yes  
No

Do you have a family history of Melanoma?  
Yes  
No  
If yes, which relative(s)? __________

**Medications:** (Please list all current medications)  
☐ NO MEDICATIONS

_____________________________________________________________________________________

**Allergies:** (Please list all allergies)  
☐ NO KNOWN DRUG ALLERGIES

_____________________________________________________________________________________

**Social History:** (Please circle all that apply)

**Cigarette Smoking:** Never smoked / Quit: former smoker / Smokes: ______ cigarettes a day ______ yrs.

**Alcohol Use:** None / If Yes, How many drinks a day? _______ Beer / Wine / Liquor

**Caffeine Intake:** How many glasses/cups a day? Tea ______ Coffee _______ Soda _______

**Sexual History:** Not sexually active / Active with one partner / Active with multiple partners

**Safety:** I feel safe at home / I do not feel safe at home

**Patients 65 yrs. Of age or older only:** I have / I have not received a Pneumonia vaccine

I have / I have not received an Influenza vaccine

**I have a Living Will:** Yes  
No
Family History: (Only first degree relatives)

Asthma: ___________________________ Heart Disease: ___________________________

Thyroid Disease: ____________________ Skin Cancer: ____________________________

Hypertension: _______________________ Diabetes: _____________________________

Mental Illness: _____________________ Other Cancers: _________________________

Review of Systems: Are you currently experiencing problems with any of the following? (Please circle any positive answers).

Constitutional: Chills / Fatigue / Fever / Unintentional Weight Gain / Unintentional Weight Loss

HEENT: Blurred Vision / Sensitivity to Light /

Cardiovascular: Rapid Heartbeat / Leg Swelling / Chest Pain / Shortness of Breath

Genitourinary: Genital Lesions / Urinary Frequency / Pain with urination / Loss of Urine with coughing

Musculoskeletal: Joint Aches / Muscle Aches / Muscle Weakness

Skin: Rashes / Itching / Sensitivity to Light

Neuro: Weakness / Dizziness / Tingling / Loss of Skin Sensation / Seizures / Headaches

Heme: Excessive Bruising / Prolonged Bleeding

Endo: Hair Loss / Excessive Hair Growth / Excessive Sweating / Thyroid

Allergy: Hay Fever / Hives

Psy: Depression / Suicidal Thoughts / Anxiety

GI: Abdominal Pain / Bloody Stool

Pulm: Shortness of Breath / Cough / Wheezing

PATIENT (Print Name): ___________________________________________ DATE: ____________

________________________________________________

PATIENT/PARENT/GUARDIAN( Signature): _______________________________
HIPAA PATIENT CONSENT FORM

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. A copy of our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Unique Dermatology & Wellness Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, workman’s comp company without your written consent.
- Protected health information may be used for treatment through one of you current doctors, payment with your insurance company or healthcare operations within our office.
- Unique Dermatology & Wellness Center has a Notice of Privacy Practices that is available for review.
- Unique Dermatology & Wellness Center reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but Unique Dermatology & Wellness Center does not have to agree to these restrictions if, for example it interferes with payment, daily operations or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Unique Dermatology & Wellness Center may condition treatment upon the execution of this consent.
- You have the right to be notified of a protected health information breach
- Unique Dermatology & Wellness Center cannot sell your health information without your permission.
- Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practice will only be made with your authorization.

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

Patient (Print Name):__________________________________ Date:____________________

Patient (Signature):__________________________ Relationship to Patient:________________

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or patient’s personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Unique Dermatology & Wellness Centers Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign ☐ Patient unable to sign ☐ Other

Employee Name:_________________________________________ Date:__________________
COSMETIC INTEREST QUESTIONNAIRE

Patient Name: ___________________________________________ Date: ______________________

Date of Birth: __________________________

Please indicate if you are interested or would like to learn more about any of the following services below: (Circle all that apply)

<table>
<thead>
<tr>
<th>Botox injections</th>
<th>Dermal Fillers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fat Reduction</td>
<td>Chemical Peels</td>
</tr>
<tr>
<td>Laser Hair Removal</td>
<td>Spider Vein Treatment</td>
</tr>
<tr>
<td>Brown spot/ Age Spot Removal</td>
<td>Acne Scarring</td>
</tr>
<tr>
<td>Skin Care Products</td>
<td>Skin Tightening</td>
</tr>
<tr>
<td>Facial Redness/ Rosacea Treatments</td>
<td>Treatment of Wrinkles</td>
</tr>
<tr>
<td>Weight Loss Program</td>
<td>Other (Please Specify):</td>
</tr>
</tbody>
</table>

Would you like to join our email list to receive exclusive information about Special Offers and Events?

☐ Yes Please provide your current email address: ________________________________

☐ No
OFFICE POLICIES ACKNOWLEDGEMENT FORM

I acknowledge that I have received and have read and understand the stated Office Policies of Unique Dermatology & Wellness Center.

Patient (Print Name): ___________________________ Date: _______________________

Patient/Parent/Guardian (Signature): __________________________________________

Relationship to Patient: ______________________________________________________