MRN: _____ Today's Date: _____/_____/_____

## PATIENT INFORMATION

Name _____
Last First Middle
Mailing Address:
_____
Street City State Zip Code
***Cell phone: (** ) _____ Home Phone: ( ) _____ Work phone: ( ) _____
**(Preferred)**
Email address: _____

Date of Birth: ____/_____/____ Last 4 of SS#: _____ Marital status: _____ Spouse's name: _____

Age:_____ Sex: _____ Race: _____ □ Employed □ FT Student □ PT Student □ Retired □ Unemployed

## NAME OF RESPONSIBLE PARTY (If different from patient above):

Mailing address of responsible party

_____
Street City State Zip
Cell phone: ( )_____ Home: ( )_____ Date of Birth: ___/____/___ Relationship: _____

## IN CASE OF EMERGENCY, NOTIFY: _____ Phone: ( ) _____

## INSURANCE INFORMATION

**After completing this form, please bring it to the front desk along with your current insurance card and photo ID.**

## PATIENT AUTHORIZATION

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the provider. I understand that Illinois Dermatology Institute uses photographs at times to ensure patient safety practices. I understand that Illinois Dermatology Institute does not permit taking videos, pictures, or audio recordings during any part of my care. I understand that backless chairs or chairs on wheels in the exam rooms are intended for use by providers or medical staff only.

I understand that payment is required for all services at the time they are rendered (unless I participate in an insurance plan that IDI accepts where all applicable copayments will be collected at the time of service). It is the patient's responsibility to check to see if the IDI provider is in-network. I am responsible for knowing the policies of my insurance, such as: co-pay coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc. Co-pays and self-pay procedures are due at the time of service, no exceptions. IDI accepts payment in the form of cash, credit card or check. I understand that if my check does not clear the bank, a $25 service fee will be automatically added to my account. I understand that any procedure performed in the office may be billed separately and in addition to the office visit fee and that as of January 2015, pathology is now billed separately from the path lab.

I will do my best to notify the office if I am going to be late to my appointment and understand it will be up to the discretion of the IDI provider as to whether or not I will be seen if arriving more than 30 minutes late. I also understand that I am responsible for a $30 charge for all missed appointments that I did not cancel at least 24 hours in advance. For the consideration of other patients who want to be seen, if I repeatedly cancel less than 48 hours in advance or repeatedly no show for my appointments, I understand that IDI has the right to discharge me as a patient.

**My signature below signifies my understanding and willingness to comply with the above policies.**

Patient or responsible party's signature: _____ Date: _____/_____/_____

If patient is a minor, Print name of responsible party: _____ Relationship: _____

Patient Name: _____ DOB: ____/____/_____ **MRN** (office use only):_____

Provider (Please circle): Dr. Mann Dr. Dickie Dr. Napatalung Today's Date: ____/_____/____

Reason for today's visit: _____

**Please check all of the following boxes that apply:**

**Past Medical History**

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation (irregular heartbeat)
☐ BPH (enlarged prostate)
☐ Bone Marrow Transplant
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD (Gastric Reflux)
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension (high blood pressure)
☐ HIV/AIDS
☐ Hypercholesterolemia (high cholesterol)
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ Other: _____
☐ ***NO PAST MEDICAL PROBLEMS***

**Past Surgeries**

☐ Appendix (Appendectomy)
☐ Bladder (Cystectomy)
☐ Breast: Mastectomy (Right Breast)
☐ Breast: Mastectomy (Left Breast)
☐ Breast: Mastectomy (Both Breasts)
☐ Breast: Lumpectomy (Right Breast)
☐ Breast: Lumpectomy (Left Breast)
☐ Breast: Lumpectomy (Both Breasts)
☐ Breast: Breast Biopsy
☐ Breast: Breast Reduction
☐ Breast: Breast Implants
☐ Colon (Colectomy): Colon Cancer Resection
☐ Colon (Colectomy): Diverticulitis
☐ Colon (Colectomy): Inflammatory Bowel Dz
☐ Gallbladder (Cholecystectomy)
☐ Heart: Coronary Artery Bypass Surgery
☐ Heart: PTCA (angioplasty)
☐ Heart: Mechanical Valve Replacement
☐ Heart: Biological Valve Replacement
☐ Heart: Heart Transplant

**Past Surgeries Continued**

☐ Joint Replacement: Knee (Right)
☐ Joint Replacement: Knee (Left)
☐ Joint Replacement: Knee (Both)
☐ Joint Replacement: Hip (Right)
☐ Joint Replacement: Hip (Left)
☐ Joint Replacement: Hip (Both)
☐ Kidney: Kidney Biopsy
☐ Kidney: Nephrectomy (Kidney Removal)
☐ Kidney: Kidney Stone Removal
☐ Kidney: Kidney Transplant
☐ Ovaries (Oophorectomy): Endometriosis
☐ Ovaries (Oophorectomy): Ovarian Cyst
☐ Ovaries (Oophorectomy): Ovarian Cancer
☐ Prostate (Prostatectomy): Prostate Cancer
☐ Prostate (Prostatectomy): Prostate Biopsy
☐ Prostate (Prostatectomy): TURP
☐ Skin: Skin Biopsy
☐ Skin: Basal Cell Carcinoma Surgery
☐ Skin: Squamous Cell Carcinoma Surgery
☐ Skin: Melanoma Surgery
☐ Spleen (Splenectomy): Spleen Removal
☐ Testicles (Orchidectomy): Testicle Removal
☐ Uterus (Hysterectomy): Fibroids
☐ Uterus (Hysterectomy): Uterine Caner
☐ Other: _____
☐ ***NO PAST SURGICAL PROCEDURES***

**Skin Disease History**

☐ Acne
☐ Actinic Keratoses (precancers)
☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous/Dysplastic Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ ***NO PAST SKIN PROBLEMS***

**Skin History**

Do you wear sunscreen?
☐ Yes. What SPF do you apply? _____
☐ No

Do you tan in a tanning salon?
☐ Yes
☐ No

**Family History of Melanoma**

*Do you have a family history of Melanoma? (Not basal cell or Squamous Cell Carcinoma)*

☐ Yes. Which relative(s)?_____
☐ No

**Family History of Other Cancer**

☐ Yes
Relative_____ Type: _____
Relative_____ Type: _____
☐ No

**Do we have your permission to import list of medications from your pharmacy?**

☐ Yes
☐ No

**Have you had a Flu shot within the last 12 months?**

☐ Yes
☐ No

**Medications: (Please list all medications, Including over the counter, supplements, etc.)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

☐ ***NO CURRENT MEDICATIONS***

**Medication Allergies: (Please list all allergies)**

1. _____
2. _____
3. _____

☐ ***NO KNOWN MEDICATION/DRUG ALLERGIES***

Over ⇨

Name_____MRN_____

**Pneumonia Vaccine**

*Did you receive the Pneumovax vaccine?*

- ☐ Yes
- ☐ No

**Drinking Alcohol History**

- ☐ No alcohol
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

**Smoking History**

- ☐ Current every day smoker
- ☐ Current some day smoker (cigarette)
- ☐ Current some day smoker (other tobacco)
- ☐ Former smoker
  Quit smoking date: ___/____/_____
  Total years smoking: _____
- ☐ Never smoker

**Review of Systems** *Have you recently experienced any of the following:*

- ☐ Changing, bleeding or itching mole/lesion
- ☐ Rash
- ☐ Itching
- ☐ Burning Skin
- ☐ Fever/Chills
- ☐ Unintentional Weight Loss
- ☐ Night Sweats
- ☐ Muscle Weakness
- ☐ Joint Aches
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Blurry Vision
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Abdominal Pain/Nausea/Vomiting
- ☐ Bloody Stool
- ☐ Depression
- ☐ Hay Fever
- ☐ Problems Healing
- ☐ Burning with urination
- ☐ Heat or cold intolerance
- ☐ Frequent nose bleeds
- ☐ ***NONE***

**Alerts** *Important info to know about you:*

- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Artificial Joint Placed in Last 2 Years
- ☐ Artificial Heart Valve
- ☐ Antibiotic Prophylaxis
- ☐ History of Scarring (Keloid)
- ☐ History of Passing Out (Vasovagal)
- ☐ Organ Transplant Recipient
- ☐ Immunosuppressed (Low Immunity)
- ☐ Allergy to Adhesive
- ☐ Pregnant or Planning a Pregnancy
- ☐ Breast Feeding
- ☐ Stomach Upset with Antibiotics
- ☐ Yeast Infection with Antibiotics
- ☐ Allergy to topical antibiotics
- ☐ Anti-coagulated (on blood thinners)
- ☐ Allergic to Lidocaine
- ☐ Rapid heartbeat with Epinephrine
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ History of MRSA
- ☐ Problem with UV therapy
- ☐ Heart Stent
- ☐ Problem with steroids
- ☐ History of stroke
- ☐ History of heart attack
- ☐ History of atrial fibrillation
- ☐ Arrhythmia
- ☐ Latex allergy
- ☐ West Africa: Travel or Contact
- ☐ ***NONE***

**Female Patients Only**

Are you pregnant?

- ☐ Yes Due Date_____
- ☐ No

Are you breastfeeding?

- ☐ Yes
- ☐ No

**Preferred Method of Contact**

- ☐ Phone: _____
  (please circle: mobile, home, work)
- ☐ Letter
- ☐ Fax: _____

**Primary Care Physician**

Name: _____
Referred you to our practice? YES or NO
Phone: _____
City: _____
Hospital Affiliation: _____

**Preferred Pharmacy Information**

Pharmacy Name _____
City_____
Street_____

**Marital status:**

☐ M ☐ S ☐ D ☐ W

**Preferred Language:**

☐ English ☐ Spanish ☐ Other_____

**Race:**

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other Race:_____

**Ethnic Group:**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

**Occupation/Workplace:**

_____

**How did you hear about us?**

- ☐ Physician: _____
- ☐ Family: _____
- ☐ Friend: _____
- ☐ Insurance Referral
- ☐ Internet search
- ☐ Other: _____

**Advanced Care Plan:** Medicare has requested us to ask **patients 65 and older**, the following question:

**Do you have an Advance Care Plan or Surrogate Decision Maker?**

(EX: Living Will, Health Care Proxy)?
___Yes ___No ____Decline to answer

**Patient/Responsible Party Signature:** _____ **Date:** _____

Reviewed by (office use): _____ Date: _____

EMA Clipboard (office use): _____

The notice of privacy practice for the office of Illinois Dermatology Institute, LLC is available at the front desk and on our website at www.illinoisderm.com/buffalogrove. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

## Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office Illinois Dermatology Institute, LLC

_____ _____

*Patient Name* *Date*

_____ _____

*Date of Birth* *MRN **(office use)***

## Section 2 – Notification and Emergency Designee

I give permission to Illinois Dermatology Institute, LLC (IDI) and staff to perform the following duties to maintain continuity of care.

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.
☐**YES** ☐**NO**
How would you like to receive your courtesy appointment reminders? (Please choose only one):
☐**Email** _____ ☐**Text** _____ ☐**Phone call**_____
Leave a message of normal test result on my home answering machine or with a specified family member.
☐**YES** ☐**NO**
Discuss medical issues with members of your household
☐**YES** ☐**NO**
The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

*Designated Person* *Contact Number*

## Section 3 – Marketing communication

IDI marketing consists of sharing **new product, discounts or service information directly to you**, our patient. The information may be communicated by letter, or email. We do not sell your information to third party companies.
☐**I wish to opt IN** and receive marketing and other communications via email, phone calls, or letter.
Email address: _____
☐**I wish to opt OUT** *I do not* wish to receive marketing information.

***I understand the information provided to me in the privacy notice and I have indicated my response to questions in each section.***

*Patient Signature and Phone number* *Date*