OWENSBORO Dermatology
2821 New Hartford Road
Owensboro, KY 42303
Tel: (270) 685-5777 | Fax: (270) 685-0190

Michael J. Crowe, MD
Board-Certified: American Board of Dermatology

Artis P. Truett III, MD
Board-Certified: Micrographic Dermatologic Surgery American Board of Dermatology

Brett A. Austin, MD
Board-Certified: Micrographic Dermatologic Surgery American Board of Dermatology

Dana N. Jennings, PA-C

Angela L. Mills, PA-C

Sandra B Cox, APRN-C

Katie Glenn, PA-C

Trevor Warfield, PA-C

Privacy Practices

I acknowledge that Owensboro Dermatology Associates, PSC has provided me a copy of their Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

_____

Patient Name *(please print)*

_____

Patient Date of Birth

_____ _____

Signature of Patient/Guardian **Date**

Affiliated Locations:

HENDERSON Dermatology
Atkinson Medical Building
1413 N. Elm St. • Suite 202
Henderson, KY 42420
Tel: 1 (888) 337-6722
Fax: (270) 830-7575

NEWBURGH Dermatology
Newburgh Dermatology
10788 Stahl Road
Newburgh, IN 47630
Tel: 1 (888) 337-6722
Fax: (270) 852-8075

ADVANCED Aesthetics
Advanced Aesthetics
2821 New Hartford Road
Owensboro, KY 42303
Tel: (270) 852-4785
Fax: (270) 852-8061

SKIN CANCER AND LASER SURGERY CENTER
Skin Cancer and Laser Surgery Center
10788 Stahl Road
Newburgh, IN 47630
Tel: 1 (888) 337-6722
Fax: (270) 685-0190

Patient Information

Please complete. We need this information before we see you.

First Name:_____MI:_____Last:_____

Billing Address:_____City:_____State:_____ Zip:_____

Date of Birth: _____/_____/_____ Sex: ___M ___F Social Security # _____

Email Address:_____

**A valid email address provided by you, authorizes us to e-mail both medical & account information.*

Marital Status:_____ Home Phone: (_____) _____ Cell Phone: (_____) _____

Employer:_____ Work Phone: (_____) _____

Primary Language: _____ Have you been here before? ____Yes _____No

Student: ____Full Time _____Part Time *(Please check one for insurance purposes.)*

In case of EMERGENCY, who should we notify?_____ Phone (_____) _____

Primary Care Physician:_____ Phone (_____) _____

Referring Physician:_____ Phone (_____) _____

How did you hear about us? (Please be specific. For example, tell us which newspaper, yellow page directory, etc.)

Newspaper:_____ Website:_____ Social Media:_____ Radio:_____

Yellow pages:_____ Health Fair:_____ Cancer Screening:_____ Lecture:_____

Relative/Friend:_____ Address:_____ City/Zip:_____

Parent or Responsible Party

Name: _____ Address:_____

Home Phone: (_____)_____Work Phone: (_____)_____ Cell Phone: (_____) _____

Date of Birth: _____/_____/_____ SS#: _____ Sex: ___M ___F Relationship:_____

Employer: _____ Address: _____

Do we have your permission to:

Leave a message on your answering machine at home?	____Yes	____No
Leave a message at your place of employment?	____Yes	____No
Discuss your medical condition with any member of your household?	____Yes	____No

If yes, whom: _____ Relationship**:** _____

Patient's Signature _____ **Date:** _____

[CONTINUED ON BACK]

*** PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST SO COPIES CAN BE MADE***

Insurance Information

This information is in regard to the person whose name appears on the insurance card.

Primary Ins. Name:_____

Ins. Address:_____

Name of Insured:_____

Insured's SS# _____

Insured's Date of Birth: _____

Insured's ID#:_____

Group#:_____

Employer Name:_____

Secondary Ins. Name: _____

Ins. Address:_____

Name of Insured:_____

Insured's SS# _____

Insured's Date of Birth: _____

Insured's ID#:_____

Group#:_____

Employer Name: _____

I authorize the release of medical information necessary to process this claim and also authorize the payment of medical benefits to the physician.

SIGNATURE: _____ DATE: _____

Payment Policies

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in the form of cash, check, or credit card. Before claims are filed, COVERAGE MAY BE PRE-VERIFIED AND YOU WILL BE ASKED TO PAY ANY UNMET DEDUCTIBLE, NON-COVERED SERVICES AND CO-PAYMENTS. **I hereby agree and understand, that after 90 days, any balance owed may be sent to a third-party entity for the purpose of collecting any outstanding amount due for services rendered, and understand that a fee of 35% may be added to balance owed.** Your signature below signifies your understanding and willingness to comply with this policy.

Medicare / Medicaid Authorization

PLEASE SIGN SO WE MAY HAVE YOUR MEDICARE AUTHORIZATION ON FILE: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, its intermediaries or carrier any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply.

Supplemental Authorization

PLEASE SIGN SO WE HAVE YOUR SUPPLEMENTAL AUTHORIZATION ON FILE: I request authorized MEDIGAP benefits to be made on my behalf for any service furnished to me. I authorized any information needed to determine these benefits payable for related services.

PATIENT'S SIGNATURE: _____ DATE: _____

Reason for Appointment

OWENSBORO Dermatology
Advanced care for healthy skin
HENDERSON Dermatology · NEWBURGH Dermatology · ADVANCED Aesthetics · SKIN CANCER AND LASER SURGERY CENTER

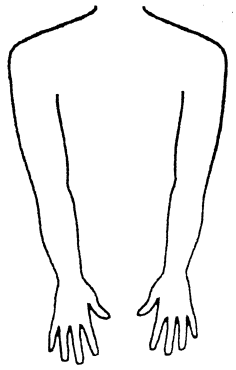
Please PRINT CLEARLY, as this will be part of your permanent medical records.

NEW RETURNING Referred by: _____ Room #: _____

Reason for appointment today: _____

_____

_____

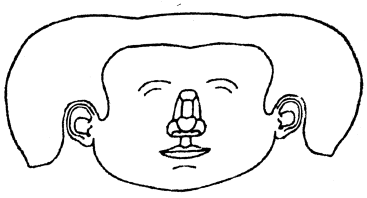


How long has this condition been present? _____

What are your symptoms, if any (itching, burning, bleeding, etc.)? Please list: _____

_____

Please list the names of prescription and over the counter medications that have been used to treat your condition (topically–creams/ointments, orally–pills) and their results?
Note: You may need to call your pharmacy for names/correct spellings:



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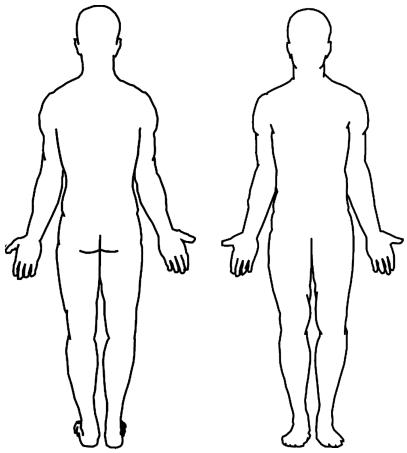

NOTES: _____

_____

_____

_____

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_____

_____

_____

Patient: _____ DOB: _____ Age: _____ Date: _____ Chart #: _____

Medication List

Please PRINT MEDICATIONS CLEARLY, as this will be part of your permanent medical records. Note: You may need to call your pharmacy to get the names of your medications.

Patient: _____ DOB: _____ Age: _____ Date: _____ Chart #: _____

ALLERGIES TO MEDICATIONS:_____

_____

MEDICATIONS	DATE OF SERVICE	REASON FOR TAKING

Preferred Pharmacy: _____ Phone: (_____)_____ City/Zip Code:_____

Patient Medical History

Please CHECK THE BOX if you have had any of the following medical conditions.

Past Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Parkinson's Disease
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ NONE
- ☐ Other:_____

_____

Past Surgical History:

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Removal)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ NONE
- ☐ Other:_____
- ☐ Solid Organ Transplant
  - ☐ Heart
  - ☐ Lung
  - ☐ Kidney
  - ☐ Other: _____

Skin Disease History:

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other:_____

_____

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)? _____

[CONTINUED ON BACK]

Social History:

Cigarette Smoking

- ☐ Currently Smokes
- ☐ Has smoked in the past
- ☐ Never smoked
- ☐ Former Smoker
- ☐ Other:_____

Alcohol Use

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day
- ☐ Other:_____

Family History *(Only first degree relatives):*

_____

_____

_____

Review of Symptoms:

- ☐ New or recent changes in moles
- ☐ Trouble taking oral antibiotics
- ☐ Enlarged lymph nodes
- ☐ Immune system problems
- ☐ Rash to bandages or tape
- ☐ Rash from oral antibiotics
- ☐ Rash from antibiotic ointment
- ☐ Other:_____

Alerts:

- ☐ Allergy to Adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotics
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heart beat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant?
- ☐ Other:_____

Thank You

One of our goals is to be known for exceptional patient care by providing the best possible service with the use of modern technology and the most effective treatments available. With a combined total of more than 60 years of experience in dermatology, you can feel confident that our dermatology specialists will provide reliability, experience, and quality you can trust.

On behalf of our physicians and staff, we would like to personally **thank you** for allowing us to serve you at one of our four convenient locations: Owensboro Dermatology, Henderson Dermatology, Newburgh Dermatology, and Advanced Aesthetics.

OWENSBORO Dermatology
Advanced care for healthy skin

HENDERSON Dermatology
NEWBURGH Dermatology
ADVANCED Aesthetics
SKIN CANCER AND LASER SURGERY CENTER

MIPS Questionnaire

Patient Name: _____

DOB: _____

Visit Date: _____

Primary Care Physician: _____

Have you had your flu shot this year? _____Yes _____No *If yes, when?* _____

Have you had a Pneumonia vaccination? _____Yes _____No *If yes, when?* _____

Do you have a living will? _____Yes _____No
If yes, who is your surrogate or power of attorney? _____

Do you drink alcohol? _____Yes _____No *If yes, what quantity?* _____

Smoking Status *(please check one)*

- ☐ Current Smoker - *sometimes*
- ☐ Current Smoker - *daily*
- ☐ Never smoked
- ☐ Former Smoker