First:____________________MI:___Last:____________________DOB:__________

Gender:___Race:____________Ethnicity:____________SSN:______________

Preferred Language:______________Email:______________________________

□ Home Phone:______________________□Cell Phone:______________________

Address:____

City/State:_____________________________________Zip Code:______________

Preferred Pharmacy:____

Primary Physician:____________________Referring Physician:________________

Emergency Contact:

Name:______________________Relation:____________Phone:______________

INSURANCE INFORMATION

Primary Insurance: __________________ **Secondary Insurance:** ______________

Address: ___________________________ Address: ___________________________

ID#: ____________Group#: ___________ ID#: ____________Group#: ____________

Policy Holder: _______________DOB:____ Policy Holder: _______________DOB:_____

Relationship to Patient: ________________ Relationship to Patient:________________

Vaccination Record

Pneumonia Vaccination: (Y/N) Date: ___________________________________
FLU Vaccination: (Y/N) Date: ____

COVID Vaccination: (Y/N) Date: ______________________________________

(65 and Older)
Do you have a health care proxy: (Y/N) Proxy: ___________________________
Do you have a living will? (Y/N)

Occupation (If retired, please list previous occupation. If disabled, list disability.):

____

Revised 04/2021

MEDICAL HISTORY

Patient:____________________ Date of Birth:_____________ Reason for Visit: _____________

Are you allergic to any medications? **NO / YES** If yes, which medications?_______________________

Current Medications:

____

Have you had or do you have any of the following conditions?

☐ Asthma ☐ Depression ☐ Hepatitis (B or C) ☐ Hyperthyroidism
☐ Atrial Fibrillation ☐ Diabetes ☐ HIV/AIDS ☐ Seizures
☐ Coronary Artery Disease ☐ COPD ☐ Hypertension ☐ Stroke
☐ Cancer:__________________________ ☐ Other: __________________________

Have you had any of the following surgeries?

☐ Heart: Replace Biological Valve ☐ Heart: Replace Mechanical Valve ☐ Ovaries: Tubal Ligation
☐ Heart: Coronary Artery Bypass ☐ Joint Replacement: Hip **(R / L)** ☐ Uterus: Hysterectomy
☐ Heart: PTCA (Stents) ☐ Joint Replacement: Knee **(R / L)**
☐ Other:____

Skin Disease History:

☐ Actinic Keratoses ☐ Dry Skin ☐ Precancerous (Dysplastic) Moles
☐ Psoriasis ☐ Basal Cell Skin Cancer ☐ Blistering Sunburns
☐ Eczema ☐ Squamous Cell Skin Cancer
☐ Other:________________ ☐ Melanoma: When /Where?________________________

Do you wear sunscreen? **NO / YES**
If yes, what SPF?_________

Tanning bed use? **NO / YES**
If yes, for how long? ___________________

Do you have a family history of Melanoma? NO / YES If yes, which relative?______________

Social History: (CIRCLE ONE)

Smoking Status: Current Smoker Former Smoker Never Smoker Total Years Smoking: _______
Alcohol Intake: None 1 or less per day 1-2 per day 3 or more per day

Are you experiencing any of the following?

☐ Problems with Bleeding ☐ Depression ☐ Bloody Urine
☐ Problems with Healing ☐ Thyroid Problems ☐ Joint Aches
☐ Problems with Scarring ☐ Sore Throat ☐ Muscle Weakness
☐ Rash ☐ Dry, Itchy Eyes ☐ Neck Stiffness
☐ Immunosuppression ☐ Blurry Vision ☐ Headaches
☐ Hay Fever ☐ Nausea ☐ Seizures
☐ Fever/Chills ☐ Vomiting ☐ Cough
☐ Night Sweats ☐ Diarrhea ☐ Shortness of Breath
☐ Unintentional Weight Loss ☐ Abdominal Pain ☐ Wheezing
☐ Anxiety ☐ Bloody Stool ☐ Chest Pain

Signature of Patient:______________________________ Date: ___________________

Revised 09/2019

Russell Dermatology of Conway
2425 Dave Ward Dr. Suite 202
Conway, AR 72034

501-328-5050 501-328-2131 russelldermatology.com

Shelley W. Russell, M.D.
Diplomate, American Board of Dermatology

E. Brian Russell, M.D.
Diplomate, American Board of Dermatology

Natalie B. Lane, M.D.
Diplomate, American Board of Dermatology

Rachel D. Choate, APRN

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____

Date of Birth: ____________________ SSN: ______________________________

I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

Name: _________________________________ Relationship: __________________

Name: _________________________________ Relationship: __________________

I understand that I am entitled to a copy of Russell Dermatology of Conway's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.russelldermatology.com or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked, this authorization shall be in force and effect one year from today's date at which time this authorization expires.

I understand that to better care for my needs, records from previous providers may be requested. I authorize Russell Dermatology to obtain these medical records on my behalf

****FOR OFFICE USE ONLY****

I authorize and request the following healthcare provider to release my medical records to Russell Dermatology:

____

____

____

____

Signature of Patient Date

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Financial Policies and Terms

Welcome to Russell Dermatology. Thank you for choosing us as your Healthcare Provider. We ask you to read the policy carefully and sign prior to your first visit.

- We ask our patients to verify with us whether your insurance carrier is currently in our network. If your insurance is out of network, please note that you will be considered a self-pay patient.
- We will file your insurance as a courtesy to you; however, it is always the patient's responsibility to make sure the insurance carrier processes the claim. All insurance benefits are to be authorized directly to Russell Dermatology. It is our policy not to file tertiary insurance.
- If an HMO referral is required by the patient's insurance, we must have a copy of this referral before the patient leaves his/her appointment or he/she will be held responsible for any charges that day.
- All copays and deductibles are due at the time of service. Any deductible, co-pay, or balance not covered by the patient's insurance will be the patient's responsibility. A $250 deposit is required of all surgical procedures that are subject to a deductible. Payment in full is required within 90 days from the date of service.
- All biopsies/procedures will be sent to a pathology company for testing. This will produce a separate charge that will be filed with your insurance. Any cost not paid by insurance will be the patient's responsibility.
- Missed appointments without 24-hour notice will be charged a fee of $50.00.
- A charge of $20.00 will be assessed by our office to complete and process information required by cancer or similar types of insurance policies.
- Cosmetic procedures are not covered by insurance **MUST** be paid for at the time of service.

I HAVE READ AND UNDERSTAND THE POLICIES AND TERMS.

____

Signature of Patient Date

Revised 09/2019