Russell Dermatology of Conway

2425 Dave Ward Dr. Suite 202
Conway, AR 72034

Appt Date: _____
Appt Time: _____
Provider: _____
Reason for Visit: _____

NAME: _____ DATE OF BIRTH: _____ GENDER: _____
PHONE: _____ EMAIL: _____ SSN: _____
ADDRESS: _____
PHARMACY: _____ PRIMARY CARE PHYSICIAN: _____
EMERGENCY CONTACT: _____ PHONE : _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

PLEASE BRING ALL INSURANCE CARDS AND IDENTIFICATION TO YOUR APPOINTMENT.

If you are unsure if your insurance is in our network, please contact our office at 501-328-5050, ext. 309.

I HEARBY AUTHORIZE RUSSELL DERMATOLOGY TO RELEASE OR DISCLOSE ALL MY MEDICAL RECORDS TO THE BELOW NAMED RECIPIENT:

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

This authorization will remain in effect until you submit a change in writing.

IS THERE A PREVIOUS DERMATOLOGIST YOU WOULD LIKE US TO REQUEST RECORDS FROM ON YOUR BEHALF? IF SO, PLEASE LIST THEM BELOW:

PREVIOUS DERMATOLOGIST: _____ CITY/STATE: _____

A separate form will be provided to you requesting permission to attain these records.

IF THE PERSON RESPONSIBLE FOR A PATIENT'S BALANCE/CHARGES INCURRED RESIDES AT A DIFFERENT MAILING ADDRESS, PLEASE PROVIDE THE RESPONSIBLE PERSON'S ADDRESS BELOW:

STREET ADDRESS/CITY/STATE/ZIP:

_____

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 copays and deductibles are due at the time of the service. Any deductible, copay, or balance not covered by the patient's insurance will be the patient's responsibility. 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. Depending on your insurance, this separate charge could come from a separate facility. 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. If you have any questions not addressed on this form, please feel free to ask our front office staff.

X_____ **X**_____ _____

Patient Signature ***Witness Signature*** ***Date***

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MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____
MEDICATION ALLERGIES: _____
CURRENT MEDICATIONS: _____
_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

___ ASTHMA
___ ATRIAL FIBRILLATION
___ DEPRESSION
___ DIABETES
___ HEART DISEASE
___ COPD
___ HEPATITIS (B or C)
___ HIV/AIDS
___ HYPERTENSION
___ HYPERTHYRODISM
___ SEIZURES
___ STROKES
___ CANCER (TYPE: _____)

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?

___ HEART VALVE REPLACEMENT
___ CORONARY BYPASS
___ PTCA (STENTS)
___ HIP REPLACEMENT (**R / L**)
___ KNEE REPLACEMENT (**R / L**)
___ HYSTERECTOMY
___ TUBAL LIGATION

SKIN DISEASE HISTORY:

___ ACTINIC KERATOSES
___ PSORIASIS
___ ECZEMA
___ DRY SKIN
___ BASAL CELL
___ SQUAMOUS CELL
___ DYSPLASTIC MOLES
___ BLISTERING SUNBURNS
___ MELANOMA

DO YOU WEAR SUNSCREEN? NO / YES SPF: ____ **TANNING BED USE?** NO / YES
DO YOU HAVE A FAMILY HISTORY OF MELANOMA? NO / YES IF YES, RELATION: _____

SOCIAL HISTORY:

SMOKING STATUS: CURRENT FORMER NEVER
ALCOHOL INTAKE: NONE 1 OR LESS PER DAY 1-2 PER DAY 3 OR MORE PER DAY
OCCUPATION (IF RETIRED, LIST PREVIOUS OCCUPATION OR DISIBILITY): _____

VACCINATION RECORD:

PNEUMONIA VACCINE: NO / YES
FLU VACCINE: NO / YES
COVID VACCINE: NO / YES

(65 AND OLDER)

DO YOU HAVE A HEALTHCARE PROXY? NO / YES
PROXY: _____
DO YOU HAVE A LIVING WILL? NO / YES

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

___ PROBLEMS WITH BLEEDING
___ PROBLEMS WITH HEALING
___ PROBLEMS WITH SCARRING
___ RASH
___ IMMUNOSUPPRESSION
___ HAY FEVER
___ FEVER/CHILLS
___ NIGHT SWEATS
___ UNPLANNED WEIGHTLOSS
___ ANXIETY
___ DEPRESSION
___ THYOID PROBLEMS
___ SORE THROAT
___ DRY, ITCHY EYES
___ BLURRY VISION
___ NAUSEA
___ VOMITING
___ DIARRHEA
___ ABDOMINAL PAIN
___ BLOODY STOOL
___ BLOODY URINE
___ JOINT ACHES
___ MUSCLE WEAKNESS
___ NECK STIFFNESS
___ HEADACHES
___ SEIZURES
___ COUGH
___ SHORTNESS OF BREATH
___ WHEEZING
___ CHEST PAIN

X _____ _____

Patient Signature ***Date***