Russell Dermatology of Conway

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

Have you had any of the following surgeries?

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

Skin Disease History:

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

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
- ☐ Problems with Healing
- ☐ Problems with Scarring
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Anxiety
- ☐ Depression
- ☐ Thyroid 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

Signature of Patient:_____ Date: _____

Revised 04/2021

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

Authorization to Release Medical Information

I hereby authorize Russell Dermatology of Conway to release or disclose all my medical records to the below named recipient(s).

Patient Name : _____ Date of Birth : _____

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

____ Substance Abuse ____ Psychological or Psychiatric Treatment ____ HIV/AIDS/STD

This authorization shall be effective until (check one):

☐ I submit a change in writing

☐ Date: _____, unless I revoke it in writing prior to this date.

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.

X _____
Patient Signature Date

X _____
Witness Signature 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, copay, 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.

X _____

Patient Signature Date