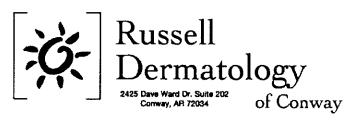


First:	MI:Last:	DOB:		
Gender:Race:	Ethnicity:	SSN:		
PreferredLanguage:	Email:			
□ Home Phone:	□Ce	il Phone:		
Address:				
City/State:		Zip Code:		
Preferred Pharmacy:				
	Referring Physician:			
Emergency Contact:				
Name:	Relation:	Phone:		
INSURANCE INFORMATION Primary Insurance: Secondary Insurance:				
Address:	Addr	ess:		
D#:Group#: _	ID#:	Group#:		
Policy Holder:	DOB:Policy	Holder:DOB:		
Relationship to Patient:	Relat	ionship to Patient:		
Pneumonia Vaccination: (Y/N) FLU Vaccination: (Y/N) Date: _	Vaccination Re	ecord		
COVID Vaccination: (Y/N) Date				
65 and Older) Do you have a health care pro 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 Ifyes, w	nich medications?		
Current Medications:	•			
Have you had or do you have a	ny of the following	ng conditions?		
□Asthma	□Depression	□Hepatitis (B or C)	□Hyperthyroidism	
☐ Atrial Fibrillation	□Diabetes	□HIV/AID\$	_ Seizures	
☐Coronary Artery Disease		☐Hypertension	□Stroke	
□Cancer:		□Other:		
Have you had any of the following		·- 		
-		an Markaniani Volus 🗇	Overier Tubel Ligation	
☐ Heart: Replace Biological Val	ve ⊔ неап: керіа	ce Mechanicai valve 🗀	Utames: Tubai Ligation	
☐ Heart: Coronary Artery Bypa			Oterus: Hysterectomy	
☐ Heart: PTCA (Stents)				
□Other:				
Skin Disease History:				
□Actinic Keratoses	☐ Dry Skin	□Precanc	erous (Dysplastic) Moles	
□Psoriasis		kin Cancer □Blisterii		
□Eczema	☐ Squamous Ce		• .	
Other:	_ •	When /Where?		
		-		
Do you wear sunscreen? NO / YES Tanning bed use? NO / YES				
Ifyes, what SPF?	Ifyes, what SPF? Ifyes, for how long?			
Do you have a family history of Mel	anoma? NO / YES	lfyes, which rela	ative?	
Social History: (CIRCLE ONE)				
Smoking Status: Current Smoker	Former Smoker	Never Smoker Total	ears Smoking:	
Alcohol Intake: None 1 or le				
		, po. 22,		
Are you experiencing any of the	e following?			
☐Problems with Bleeding	Depres	-	Bloody Urine	
□ Problems with Healing			Joint Aches	
☐ Problems with Scarring	☐ Sore Ti		Muscle Weakness	
□Rash	☐ Dry, Ito	, -,	Neck Stiffness	
☐ Immunosuppression	☐ Blurry /		Headaches	
☐ Hay Fever	□Nausea	_	Seizures	
☐ Fever/Chills	□Vomitir	•	Cough	
☐ Night Sweats	□ Diarrhe	_	Shortness of Breath	
☐ Unintentional Weight Loss	□Abdom		Wheezing	
☐ Anxiety .	□Bloody	Stool	Chest Pain	
Signature of Patient:Revised 04/2021		Date: _		
IVE AIDEM OFITANT I				



Shelley W. Russell, M.D. Urphomate. American Board of Dermatolog.

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

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

Rachel D. Choate, APRN

📞 501-328-5050 📻 501-328-2131 🦻 russelldermatology.com

Authorization to Release Medical Information

Patient Name :	Date of Birth :
Name	Relationship to Patient
	portions of your medical records released, please ition you do not want released.
Substance Abuse	Psychological or Psychiatric Treatment HIV/AIDS/STD
This authorization shall be effecti	until (check one):
☐ I submit a change	writing
☐ Date:	, unless I revoke it in writing prior to this date.
understand that I am entitled to a copy opy of the Notice of Privacy Practices f	Russell Dermatology of Conway's Notice of Privacy Practices. I can access the website www.russelldermatology.com or from the office directly.
X	X



Shelley W. Russell, M.D. Diplomate American Scard of Decharology

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

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

Rachel D. Choate, APRN

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

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