KENTUCKY DERMATOLOGY & SKIN CANCER CLINIC, PSC
177 Burt Road – Lexington KY 40503
859.276.1511 Fax 859.276.3373
Clifton Smith, M.D. – John Roth, M.D.

PLEASE PRESENT YOUR ID, INSURANCE CARDS AND CO-PAY WITH YOUR COMPLETED PAPERWORK

PATIENT INFORMATION **ANSWER ALL QUESTIONS – PLEASE PRINT**

First Name ____________________ MI __________ Last Name ____________________________________

Address _________________________________ City / State / Zip _________________________________

Home ( ) ______-__________ Work ( ) ________________ Cell ( ) _______________

Phone # to leave message with Confidential Medical Information ________________________

Date of Birth ____________ Age ______ SS# ________________________ Gender M/F ____________

Occupation____________________ Employer________________________ Marital Status S / M / W ______

Does your INS Company require a specific lab for lab or pathology test? If so, please note: ________________ Choice Care □ yes

Person(s) authorized to discuss or receive my medical information: ____________________________________

Patient Email: ____

Primary Care Physician: ____ City: ___________________

Referring Physician: ____ City: ___________________

Emergency Contact: ___________________________ Relationship _____________ Phone: ______________

PARENT OR RESPONSIBLE PARTY (if different from patient) Relationship to Patient________

First Name ____________________ MI __________ Last Name ____________________________________

Address _________________________________ City_________________ State_______ Zip__________

Home ( ) ________________ Work ( ) ________________ Cell ( ) _______________

Date of Birth ___/___/___ Age______ SS#__________________ Employer ___________________

I have received information regarding the providers of care in this organization. This facility follows all guidelines recommended by the Center for Disease Control as well as yearly in-services regarding infection, hand washing, appropriate surgical technique, and sterile procedures. All infections are monitored and reported as required.

Your surgical procedure will be performed by a trained and qualified Provider at Kentucky Dermatology & Skin Cancer Clinic, PSC. Dr. Smith, Dr. Roth, Ragan Davies, APRN, Angela Ballard, APRN, Elizabeth Lowrey, APRN, Kris Moghadamian, PA-C, or Ashley Sutton, PA-C, will be performing your procedure/surgery.

I authorize the release of medical information to my primary care or referring physician to consultants if needed and as necessary to perform insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company. This includes, but not limited to, co-pays, deductibles, and co-insurance payments for medical, surgical, or office-based surgery suite fees. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event your check is dishonored or returned for any reason, you authorize us to re-present the check to your account for the collection of the check, plus any applicable fees as permitted by state law. Your medical insurance plan may require you to pay a percentage, copayment, or deductible.

We require a 24-hour notice to cancel or reschedule appointments.
<u>I may be responsible for paying a fee of $75.00 for a missed office visit, $100.00 for a missed surgery appt, or a $250.00 for a missed RF appt.</u>

I agree to provide proof of identity in any form required but not limited to photo ID and a photo taken at the time of treatment. I give my permission to Kentucky Dermatology for the treatment of my dermatological conditions. I acknowledge that I have read and agree to abide by these policies.

_______________ X_________________________________ Date: ___/___/____
Receptionist's Initials Patient or Responsible Party Signature

Kentucky Dermatology & Cosmetic Specialists

History & Intake Form

First Name: ______________________ MI: ____ Last: ____________________ Date: __________
Occupation: ___________________________ Employer: ______________________________
Reason for Visit: ____

Medications –List all CURRENT medications include strength and dosage:

Pharmacy Name: _______________________ ______________________________________

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

_____by initialing, I am giving Kentucky Dermatology permission to reconcile my prescription list with information SureScripts regarding; medications, strength, dosages, etc.

Allergies – List all allergies and reactions if known

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Medical History-Select any of the following medical conditions you currently have or have had:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ PBH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

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Past Surgical History – Have you had any surgeries on the following organs? ☐ **NONE**

- ☐ Appendix
- ☐ Bladder
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (RT, Lt, Both)
- ☐ Breast: Mastectomy (RT, Lt, Both)
- ☐ Colon (Type):
- ☐ Gall Bladder
- ☐ Heart: Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Valve Replaced
- ☐ Joint Replace: Hip (RT, Lt, Both)
- ☐ Joint Replace: Knee (RT, LT, Both)
- ☐ Other ______________________________
- ☐ Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: liver Transplant
- ☐ Liver: Other
- ☐ Ovaries: Ovarian Cancer
- ☐ Ovaries: Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Biopsy
- ☐ Prostate: Prostate Cancer
- ☐ Prostate (Prostatectomy: TURP
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterine Cancer (Hysterectomy)
- ☐ Cervical Cancer (Hysterectomy)
- ☐ Rectum: APR
- ☐ Kidney: Biopsy
- ☐ NONE

Skin Disease history _Have you had any of the following?

☐ Acne ☐ Dry Skin ☐ Poison Ivy ☐ Stroke
☐ Actinic Keratosis ☐ Eczema
☐ Asthma ☐ Flaking or Itchy Scalp ______________________
☐ Basal Cell Skin Cancer ☐ Hay Fever / Allergies ______________________
☐ Blistering Sunburns ☐ Melanoma ______________________

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?
☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Daughter ☐ Son ☐ Uncle ☐ Aunt ☐ Other ______________

Smoking Status: ☐ Current Every Day ☐ Current occasional ☐ Former smoker ☐ Never smoker
Alcohol Intake: ☐ None ☐ 1 or less per day ☐ 1-2 per day ☐ 3 or more per day

Family History – Please include relationship of person to you

☐ Psoriasis ______________ ☐ Asthma ______________ ☐ other diseases related to your visit:
☐ Skin Cancer______________ ☐ Diabetes ______________ ______________________
☐ Eczema ______________ ☐ Arthritis______________ ______________________
☐ Hay Fever______________ ☐ Cancer ______________ ______________________

Height: _____**ft.** ________**inches** **Weight** __________ **lbs.**

Review of Systems – Please check yes or no for the following:

Anemia or problems with Bleeding	☐ Yes	☐ No	History of Hepatitis	☐ Yes	☐ No
Problems with Scarring (hypertrophic or keloid)	☐ Yes	☐ No	History of Arthritis	☐ Yes	☐ No
Eczema / Psoriasis	☐ Yes	☐ No	Headaches or Seizures	☐ Yes	☐ No
Immunosuppression	☐ Yes	☐ No	Asthma/ Lung Disease	☐ Yes	☐ No
Allergies / Hay Fever	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Anxiety / Depression	☐ Yes	☐ No
Flu like Symptoms	☐ Yes	☐ No	Diabetic	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Other: ____________	☐ Yes	☐ No

Alerts:

Allergy to Latex	☐ Yes	☐ No	Skin Infections	☐ Yes	☐ No
Allergy to ANY Medications	☐ Yes	☐ No	Do you require premedication before procedures	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No	Pregnant or planning to become pregnant	☐ Yes	☐ No

______________________ ____________ ____________ ____________
Patient or Guardian Signature **Date** **Staff Initials** **Provider Initials**