Patient Name: _____ DOB: _____

Primary care doctor: _____ Who referred you today? _____

☐ I do not permit MD Dermatology to disclose any information regarding my care or treatment to anyone without my written permission or legal authorization

☐ I permit MD Dermatology to disclose any information regarding my care and treatment to:

_____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy City and State: _____

MEDICAL HISTORY AND INTAKE FORM

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH (Enlarged Prostate)
Cancer: Type(s)_____
COPD (Chronic Obstructive Pulmonary Disease)
Coronary Artery Disease Depression
Diabetes
End Stage Renal (Kidney) Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis/Liver Disease
Hypertension(High Blood Pressure)
HIV/AIDS
Hypercholesterolemia (High Cholesterol)
Hyperthyroid (Overactive Thyroid)
Hypothyroid (Underactive Thyroid)
Radiation Treatment
Seizures
Stroke
None
Other_____
_____

Have You Had Surgery On Any Of The Following Organs: (Please circle all that apply)

Appendix (Appendectomy) Bladder (Cystectomy)
Breast: Breast Biopsy
Breast: Lumpectomy
Breast: Mastectomy
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gall Bladder Removed
Heart: Biological Valve Replacement
Artery Bypass Surgery
Heart: Heart Transplant Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: Hip (right/left)
Joint Replacement: Knee (left)
Joint Replacement: Knee (Right)
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries(Oophorectomy): Endometriosis
Ovaries(Oophorectomy): Ovarian Cyst
Ovaries(Oophorectomy): Ovarian Cancer Ovaries: Tubal Ligation
Pancreas: Pancreatecomy
Prostate(Prostatectomy): Prostate
Biopsy Prostate(Prostatectomy): Prostate Cancer
Prostate: TURP
Rectum:APR
Rectum: Lower Anterior Resection
Skin: Melanoma
Skin: Biopsy
Spleen (Splenectomy)
Testicles(Orchiectomy)
Uterus(Hysterectomy): Fibroids
Uterus(Hysterectomy): Uterine Cancer Uterus(Hysterectomy): Cervical Cancer
OTHER_____
_____
_____

Skin Disease History: *(please circle all that apply)*

Acne
Dry Skin
Poison Ivy
Actinic Keratosis (pre-cancerous lesions)
Eczema
Precancerous Moles
Asthma
Flaking or Itchy Scalp
Psoriasis
Basal Cell Skin Cancer
Hay Fever/Allergies
Squamous Cell Cancer
Blistering Sun Burns

Do you wear sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Family History: (please circle all that apply and write which relative)

Melanoma If yes, which relative(s)?_____

Acne	Eczema	Non-Melanoma Skin Cancers
Diabetes	Psoriasis	Other:
Lupus	Asthma	_____
Arthritis	Hay Fever/Allergies	_____

Medications: (Please list all current medications)

Name:_____Dose:_____Frequency:_____

_____

_____

_____

Medication ALLERGIES: NONE (Please circle if no medication allergies)

_____

_____

Social History:

Smoking Status: (Please circle one)	*Alcohol Status: (Please circle one)*
Current every day smoker	None
Current some day smoker	Less than 1 drink per day
Former smoker	1-2 drinks per day
Never smoker	More than 3 drinks per day

During flu season did you receive the flu vaccination? YES NO No - I am allergic

If you are over 65 please answer the following:

Do you have a living will or advance directive: YES NO

Do you have a surrogate decision maker to assist in medical decision making: NO

If yes Name: _____ Contact number : _____

Have you ever received the pneumonia vaccination? YES NO

Review of Systems: Do you have or are you currently experiencing any of the following? (Please circle yes or no)

Changing mole	Yes No	Pacemaker	Yes No	Thyroid problems	Yes No
Rash	Yes No	Immunosuppression	Yes No	Allergy to antibiotic ointment	Yes No
Fever or chills	Yes No	Defibrillator	Yes No	Artificial heart valve	Yes No
Headaches	Yes No	Hay fever	Yes No	Artificial joint (past 2 yrs)	Yes No
Depression	Yes No	Blood thinners	Yes No	MRSA	Yes No
Anxiety	Yes No	GI upset with antibiotics	Yes No	Premedication	Yes No
Problems with healing	Yes No	Allergy to adhesive	Yes No	Rapid heartbeat w epinephrine	Yes No
Problems with bleeding	Yes No	Unintentional weight loss	Yes No	Joint aches	Yes No
Problems with scarring	Yes No	Allergy to lidocaine	Yes No	Pregnancy/planning	Yes No

PATIENT CONSENT FOR USE DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Sanjiv K. Saini, MD, LLC may use and disclose protected health information(PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Sanjiv K. Saini, MD, LLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent Sanjiv K. Saini, MD, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A Notice of Privacy Practices may be obtained by forwarding a written request to Sanjiv K. Saini MD Privacy Officer at 3168 Braverton Street, Suite 340 Edgewater, MD 21037.

With my consent, Sanjiv K. Saini, MD, LLC may call my home or other designated locations and leave a message on a voicemail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

I promise to follow medical recommendations made by the doctor and the staff who treat me. In the event I do not follow up with the recommended treatment plan, I fully accept the consequences of my failure to do so and fully release all providers, staff and organizations associated with my care from all present and future liability.

By signing this form, I am consenting to Sanjiv K. Saini, MD, LLC's use and disclosure of PHI to carry out TPO.

If I do not sign this consent, Sanjiv K. Saini, MD, LLC may decline to provide treatment to me.

Patient/Legal Guardian Signature _____ Date _____

Patient's Printed Name _____ DOB _____

FINANCIAL AGREEMENT OF OFFICE POLICIES

I the undersigned, consent to the use and diclosure of my protected health information for the treatment, payment, operations, and such other purposes that are permitted under the Federal Health Insurance Portability and Accountability Act without a written authorization.

I accept that I am financially responsible for all services rendered on my behalf by Sanjiv K. Saini, MD/ MD Dermatology and Laser Center. For those insurance plans for which the practice accepts assigments, I accept personal responsibility for all copayments, deductibles, and non-covered services, as dictated by my insurnace coverage. This constitutes a formal consent & waiver to obtain medical services in the event my insurance plan requires a referral and I have not obtained one.

I accept financial responsibility for all fees incurred including any collection/attorney fees the practice incurs in collecting payments for which I am responsible. I authorize the entities, or their designed respresentatives, to charge 40% additional amount that may be incurred in the collection of any unpaid debts. I understand that I am liable for these charges should I become deliquent in my payments to the practice.

When you are scheduled for an appointment we have set aside time to address your questions and concerns. Therefore, it is essential that all patients arrive at their scheduled time. Should you arrive **15 minutes late** for your scheduled appointment time, your appointment will/may need to be rescheduled.

Our office has a cancellation policy. At least 24 hours notice is required when canceling your appointment. A $50.00 fee will be charged if proper notification is not given.

For surgeries, three (3) business days notice is required when canceling the appointment. A $100.00 fee will be assessed if proper notification is not given.

Please sign stating that you have read, understand, and accept these policys.

Patient/Legal Guardian Signature _____ Date _____

Patient's Printed Name _____ DOB _____

NOTICE OF PRIVACY PRACTICES

- This notice describes how your health information may be used and disclosed and how you can access this information.
- At MD Dermatology we are required to keep your health information secure and confidential by law. Also by law we need to give you this notice and follow the terms outlined.
- The law permits us to use or disclose your health information to those involved in you treatment. For Example: we may send a report of your treatment or progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with all business associates that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments, If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency we may disclose your health information to a family member or another person responsible for your care.
- We will need to release some or all of your health information when required by law.
- If this practice is sold you information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization. This includes use in marketing and fundraising.
- You may request in writing that we not use or disclosures we make with your health information beyond the above normal uses.
- You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication methods, number or system you prefer.
- You have the right to see and receive a copy of your health information with a few exceptions. Give us a written request regarding the information you want to see. if you want a copy of your records we may charge you a reasonable fee for copies. If you would like a digital copy for you records, we will try to accommodate your request.
- You have the right to receive a report of who we disclose your information to.
- If our privacy and security measures or systems are breached in any way we will notify you.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services in writing (200 Independence Ave, SW Room 509F, Washington DC 20201) online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.
- Please contact our privacy officer/clinical coordinator at 410-956-7777 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgement: I have read and have been offered a copy of these privacy practices. Date: _____

Sign:_____ Name: _____