History and Intake Form

Patient Name: _____

Date of Birth: _____

Past Medical History: (please circle all that apply)

Anxiety	Diabetes	Leukemia
Arthritis	End Stage Renal	Lung Cancer
Asthma	Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood pressure	Stroke
Colon Cancer	HIV/AIDS	Syncope/Fainting
COPD	High Cholesterol	
Coronary Artery Disease	Thyroid Problems	NONE
Depression	-Hypo / Hyper	

Other _____

Patient Name: _____
Date of Birth: _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Ovaries Tubal Ligation
Pancreas: Pancreatectomy
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Squamous Cell Carcinoma
Skin: Melanoma
Skin: Biopsy
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical CA
Other _____

NONE

FEMALE ACNE PATIENT
Last Menstrual Cycle: _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin

NONE

Other _____

Patient Name: _____
Date of Birth: _____

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(s)? _____

Medications: (Please enter all current medications)

_____
_____
_____

Drug Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Never smoked
Former Smoker

Alcohol Use:

None
Less than 1 drink per social/day
1-2 drinks per day
3 or more drinks per day

Other_____

Family History (Please include relationship and Disease)

_____
_____
_____
_____

Preferred Language: _____
Race:_____ Ethnic Group: Hispanic Non-Hispanic

PHARMACY INFORMATION
Name: _____ *mandatory
Phone#: _____
City or Zip code:_____*mandatory

Patient Name: _____
Date of Birth: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Rash		
Problems with Bleeding		
Problems with Healing		
Problems with Scarring		
Immunosuppression		
Hayfever		
Chest Pain		
Fever or Chills		
Night Sweats		
Unintentional Weight Loss		
Thyroid Problems		
Sore Throat		
Blurry Vision		
Abdominal Pain		
Bloody Stool		
Bloody Urine		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Headaches		
Seizure		
Cough		
Shortness of Breath		
Wheezing		
Anxiety		
Depression		
Pregnancy		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to Epinephrine
Allergy to Iodine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
HIV/AIDS
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine

Are you pregnant or currently trying to get pregnant? YES or NO

3168 Braverton Street, Suite 340
Edgewater, MD 21037
410-956-7777
410-956-7186 FAX

MD DERMATOLOGY

22335 Exploration Drive, Suite 2005
Lexington Park, MD 20653
301-863-7310
301-863-7642 FAX

PATIENT INFORMATION FORM

Date _____ Birth Date M/D/Y _____

Last Name _____ First Name _____ Initial _____

Address _____ City _____ State _____ Zip Code _____

Referred by _____ Home Phone _____

Cell _____ Work Phone _____ Email _____

Occupation _____ SSN _____ Sex _____ Marital Status _____

Emergency Contact _____ Emergency Phone _____

Primary Insurance _____ Policy Holder _____

Policy # _____ Relationship _____ Birth Date M/D/Y _____

Group # _____ Employer _____

Secondary Insurance _____ Policy Holder _____

Policy # _____ Relationship _____ Birth Date M/D/Y _____

Group # _____ Employer _____

Guarantor's Name _____

Address _____ City _____ State _____ Zip Code _____

Phone _____

Ethnicity: *Circle One Please* Hispanic Origin Non-Hispanic

Language: _____

Race: *Circle One* American Indian Asian Black
Type-Unknown White Native Hawaiian

Please check the boxes below if you accept:

☐ Please text me my appointment reminders at this number: _____

☐ Please Opt me in to receive email notifications relating to specials and promotions.

My email address is: _____

How did you hear about us? _____

PATIENT'S AUTHORIZATION

The undersigned, consents to the use and disclose of my protected health information for the treatment, payment, operations and such other purposes that are permitted under Federal Health Insurance. Portability and Accountability Act without written authorization. I accept that I am financially responsible for all services rendered on my behalf by Sanjiv K. Saini, MD / MD Dermatology of Maryland, LLC. For those insurance plans for which the practice accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. This constitutes a formal consent & waiver to obtain medical services in the event my insurance plan requires a referral & 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 payment directly to the practice for services for which the practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

Signature of patient/ parent/ legal Guardian _____ Date _____

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E-SCRIBE FORM

Effective June 1, 2011 we are now using e-scribe to submit your prescriptions. Please provide us the following information.

Thank You

Pharmacy Name _____

Address _____

City _____ State _____ Zip code _____

Phone _____

ALLERGIES:

_____

_____

_____

YOUR NAME _____

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Sanjiv K. Saini, MD / MD Dermatology of Maryland, LLC

I, the undersigned, consent to the use and disclosure 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 of Maryland, LLC. For those insurance plans for which the practice accepts assignments, I accept personal responsibility for all copayments, deductibles, and non-covered services, as dictated by my insurance coverage. This constitutes a formal consent & waiver to obtain medical services in the event my insurance plan requires a referral & 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, about or their designated representatives, 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 Sanjiv K. Saini, MD LLC.

I promise to follow medical recommendations made by the doctor and staff who treat me. In the event I do not follow up with the recommended treatment plan made by the providers, 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. I promise to accept full responsibility for my actions. In the event that I fail in my responsibility to follow recommended medical advice, I promise to

I authorize payment directly to the practice for services for which the practice accepts assignments. A copy of this agreement may be used in place of the original.

I understand the jurisdiction for any legal actions will be done in St. Mary's County in Maryland.

I certify that the information stated on this form is correct.

Signature of patient/ parent/ legal Guardian _____ Date _____

Print Patient Name _____ Patient's DOB _____

Witness _____ Date _____

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MD DERMATOLOGY
OF MARYLAND

22335 Exploration Drive, Suite 2005
Lexington Park, MD 20653
301-863-7310
301-863-7642 FAX

NOTICE OF OFFICE POLICIES

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 ten (10) minutes late for your scheduled appointment time, your appointment will/may need to be rescheduled.

Our office has a cancellation policy. At least three (3) business days notice is required when canceling your appointment. A $50.00 fee will be charged if proper notification is not given.

For surgeries, seven (7) business days notice is required when canceling the appointment. A $100.00 fee will be assessed if proper notification is not given.

Please sign at the bottom stating that you have read, understand, and accept this policy.

Patient / Legal Guardian Signature _____ Date _____

Patient's Printed Name _____ Date _____

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MD DERMATOLOGY of MARYLAND

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301-863-7642 FAX

DISCLOSURE TO FAMILY/ FRIENDS FORM

☐ I do not want Sanjiv K. Saini, MD / MD Dermatology of Maryland, LLC to disclose any information concerning my care or treatment by provider to individuals without my expressed written consent or legal authorization.

☐ I authorize Sanjiv K. Saini, MD / MD Dermatology of Maryland, LLC to disclose any information related to my care and treatment to the following named individuals:

NAME _____ NAME _____

NAME _____ NAME _____

NAME _____ NAME _____

NAME _____ NAME _____

The authorizations provided above are subject to the following limitations or restrictions:

Patient's Signature (or legally responsible individual) _____ Patient DOB _____

Print Name _____ Date _____

Witness _____ Date _____

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of MARYLAND

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PATIENT CONSENT FOR USE AND 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 review 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 voice mail or in person 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.

With my consent, Sanjiv K. Saini, MD, LLC may mail to my home or to other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential".

With my consent, Sanjiv K. Saini, MD, LLC, may e-mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Sanjiv K. Saini, MD, LLC restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. 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 _____

Patient's DOB _____

South River Ambulatory Surgery Center, LLC (SRASC)
Sanjiv K. Saini, MD LLC (SKS)
NOTICE OF PRIVACY PRACTICES

- This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.
- At SRASC and SKS, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. 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 each business associate 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, your 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 disclose some or all of your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses 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 method, number or system you prefer to contact you.
- You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.
- 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 the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.
- You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- 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 Avenue, S.W, 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, Christine Little, 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.

Acknowledgment

I have received a copy of the SRASC and SKS Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____