Date: _____

Patient Name: _____ DOB: _____

Referring Provider: _____

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
Joint Replacement: Knee
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)

Melanoma If yes, which relative(s)?_____

Acne
Diabetes
Lupus
Arthritis

Eczema
Psoriasis
Asthma
Hay Fever/Allergies

Non-Melanoma Skin Cancers
Other:
_____
_____

Medications: (Please list all current medications)

_____
_____
_____
_____

MEDICATION ALLERGIES:

_____
_____

Social History:

Smoking Status: (Please circle one)
Current every day smoker
Current some day smoker
Former smoker
Never smoker

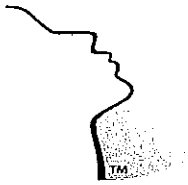
Alcohol Status: (Please circle one)
None
Less than 1 drink per day
1-2 drinks per day
More than 3 drinks per day

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

Changing mole Yes No
Muscle weakness Yes No
Rash Yes No
Neck Stiffness Yes No
Fever or chills Yes No
Headaches Yes No
Depression Yes No
Seizures Yes No
Anxiety Yes No
Cough Yes No
Problems with healing Yes No
Shortness of breath Yes No
Problems with bleeding Yes No
Wheezing Yes No
Problems with scarring (hypertrophic or keloid) Yes No

Pacemaker Yes No
Immunosuppression Yes No
Defibrillator Yes No
Hay fever Yes No
Blood thinners Yes No
Chest pain Yes No
GI upset with antibiotics Yes No
Night sweats Yes No
Allergy to adhesive Yes No
Unintentional weight loss Yes No
Allergy to lidocaine Yes No
Thyroid problems Yes No
Allergy to topical antibiotic ointments Yes No
Sore throat Yes No
Artificial heart valve Yes No

Blurry vision Yes No
Artificial joint within the past 2 years Yes No
Abdominal pain Yes No
MRSA Yes No
Bloody stool Yes No
Premedication prior to procedures Yes No
Bloody urine Yes No
Rapid heartbeat with epinephrine Yes No
Joint aches Yes No
Pregnancy or planning a pregnancy Yes No



MD DERMATOLOGY
OF MARYLAND

PATIENT INFORMATION FORM

Date_____ Birth Date M/D/Y_____

Last Name _____ First Name_____ Initial_____

Address_____ City _____ State_____ Zip Code_____

Home Phone _____ Cell Phone _____

Email_____ Sex_____

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* Hispanic Origin Non-Hispanic

Language:_____

Race: *Circle One* American Indian Asian Black

Type- Unknown White Native- Hawaiian

DISCLOSURE TO FAMILY/FRIENDS

☐ I don't want MD Dermatology and Laser Center, LLC to disclose any information concerning my care or treatment by provider to other individuals without my written consent or legal authorization.

☐ I authorize MD Dermatology and Laser Center, LLC to disclose any information related to my care and treatment to the following individuals:

NAME _____ NAME_____

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 _____

Patient's DOB _____

FINIANCIAL 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 _____

Patient's DOB _____

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 this practice, 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.
- 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.
- 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 Notice of Privacy Practices. Date _____

Signature_____

Print Name_____

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