Alpine Dermatology Associates, P.L.L.C.

1785 Kipling St.
Lakewood, Colorado 80215
(303) 935-4681

MEDICAL HISTORY

Patient Name _____ Date _____

Are you allergic to any medications? Yes/No If yes, please list:

1. 3.
2. 4.

LIST ALL MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBAL) YOU ARE CURRENTLY TAKING:

1. 4.
2. 5.
3. 6.

HISTORY OF MEDICAL PROBLEMS

Do you have or have you ever had problems with…Circle (Y)es or (N)o:

Systemic

Diabetes .....Y N
Thyroid .....Y N
Kidney/urinary tract .....Y N
Stomach .....Y N
Bowels/gall bladder .....Y N
Liver/spleen/hepatitis .....Y N
Allergies/hay fever/sinus .....Y N
Seizures/epilepsy.....Y N
Fainting .....Y N
Glaucoma/eyes .....Y N
Alcoholism.....Y N
AIDS exposure.....Y N
Phlebitis .....Y N
Arthritis.....Y N

Lungs

Asthma .....Y N
Emphysema .....Y N
Bronchitis.....Y N
Morning cough .....Y N
Chronic cough .....Y N
TB/clots in lungs.....Y N

Vascular

High blood pressure.....Y N
Chest pain.....Y N
Heart attack.....Y N
Heart murmur.....Y N
Irregular/fast heart beat .....Y N
Pacemaker.....Y N

Other: _____

Reviewed by: _____ Date: _____
Darnell Martin-Wimmer, M.D.

Patient Name _____

FAMILY HISTORY OF MEDICAL DISEASES

Cancer.....Y N
High blood pressure.....Y N
Heart disease.....Y N
Stroke.....Y N
Arthritis.....Y N
Diabetes.....Y N
Allergy/hay fever/sinus.....Y N
Family history of skin diseases.....Y N

Other: _____

LIST PAST SURGERIES AND APPROXIMATE TIME/AGE

_____

_____

PLEASE ANSWER THE FOLLOWING

1. Do you smoke/chew tobacco?.....Y N How much?_____
2. Do you use recreational drugs?.....Y N Which drug(s)? _____
3. Do you bleed easily/aspirin.....Y N
4. Any artificial joints?.....Y N Where? _____
5. **Women:**

   Are you pregnant?.....Y N Due date _____
   Breast feeding?.....Y N
   Are you on the Pill?.....Y N Depoprovera shots? Y N Estrogen? Y N
   Progesterone?.....Y N

SKIN HISTORY

1. Where did you grow up?_____ Were you a lifeguard? Y N
2. How many blistering sunburns did you get before age 21? ____
3. Anyone in your family have skin cancer?...Y N
   - Basal cell.....Y N
   - Squamous cell.....Y N
   - Melanoma.....Y N
   - Pre cancer.....Y N
4. Have <u>you</u> had skin cancers?.....Y N
   - Basal cell.....Y N
   - Squamous cell.....Y N
   - Melanoma.....Y N
   - Pre cancer.....Y N
5. Do you have a history of skin disease?.....Y N
6. Any other diseases or conditions we should know about? Please describe:

   _____
7. Do you use sunscreen regularly?.....Y N
8. Any surgery done in the past 6 months?....Y N If yes, what and when:

   _____
9. What is your occupation? _____
10. What are your hobbies?_____

Completed by: ____Patient ____Other relationship _____ ____Medical assistant

Reviewed by: _____ Date: _____
Darnell Martin-Wimmer, M.D.

REVIEW OF SYSTEMS

Patient Name: _____ Date of Birth _____
What are we seeing you for today? _____
_____

Constitutional Symptoms	**Yes**	**No**
Fever or chills	☐	☐
Excessive weight loss or gain	☐	☐
Fatigue	☐	☐
Skin		
Rashes or color changes	☐	☐
Itching or dryness	☐	☐
Hair or nail changes	☐	☐
Changing moles	☐	☐
Eyes		
Loss of vision	☐	☐
Distorted vision or haloes	☐	☐
Eye pain or soreness	☐	☐
Ears, Nose, Mouth, Throat		
Hearing difficulty	☐	☐
Ringing or dizziness	☐	☐
Sinus congestion	☐	☐
Runny nose/post-nasal drip	☐	☐
Nose bleeds	☐	☐
Dryness/hoarseness	☐	☐
Cardiovascular		
Chest pains or palpitations	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐
Endocrine		
Heat or cold intolerance	☐	☐
Excessive thirst or hunger	☐	☐

Date: _____
Reviewed by: Dr. Darnell Martin-Wimmer

Gastrointestinal	**Yes**	**No**
Swallowing difficulty	☐	☐
Vomiting/heartburn	☐	☐
Constipation/diarrhea	☐	☐
Nausea/vomiting	☐	☐
Genito-urinary		
Urinary frequency	☐	☐
Urinary pain or blood	☐	☐
Females		
Currently pregnant	☐	☐
Breast masses or discharge	☐	☐
Vaginal bleeding/discharge	☐	☐
Pelvic pain	☐	☐
Musculoskeletal		
Joint pain, swelling, redness	☐	☐
Muscle pain or cramps	☐	☐
Neurological		
Headaches/migraines	☐	☐
Numbness or tingling	☐	☐
Weakness or paralysis	☐	☐
Fainting or blackouts	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Hematological/Lymphatics/Immunology		
Easy bruising/bleeding	☐	☐
Blood transfusions	☐	☐
Swollen lymph nodes	☐	☐

Other symptoms not listed above: _____
_____
_____

ALPINE DERMATOLOGY ASSOCIATES
FINANCIAL POLICY

Welcome to Alpine Dermatology. In order for us to be able to deliver the quality of care that you are accustomed to, we have established these financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality of care and make your visit as pleasant as possible. **PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY INITIALING AND SIGNING BELOW.**

When asked, and as a courtesy to you, we will try to give you general guidelines about what your insurance might cover. Since medical insurance is an agreement entered into by you and your insurance carrier, **YOU ARE ULTIMATELY RESPONSIBLE FOR KNOWING THE SPECIFICS OF WHAT YOUR POLICY COVERS.**

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone numbers, please notify the receptionist and we will give you a form to update.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. My copayment for each visit is $_____. My annual deductible is $_____ of which $_____ has been met for this year. If you have a balance after an insurance payment from a previous visit, we will also ask for that payment. We accept cash, checks, Visa and MasterCard . _____(please initial)
4. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within *60 days* of being submitted, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. You will be responsible at the time of service for payment of annual deductibles, copayments, charges for noncovered or cosmetic services* _____(please initial)

   ***You will be asked to sign a Waiver of Liability form in the event that service is provided which we know is not, or have reason to believe may not be, covered by Medicare.**

   ***If your insurance requires a referral for specialty care, it is your responsibility to obtain the correct referral. You will be responsible for any services rendered without the proper referral.**

5. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your payment will be collected at the time of service. If we do not participate with your plan, we will provide you a receipt to file with your insurance company and full payment will be expected at the time of service. _____(please initial)
6. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay in full at the time of service. _____(please initial)
7. NO SHOW OR MISSED APPOINTMENTS: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not cancelled in advance, and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there *may* be time when you are unable to keep an appointment, but we ask the courtesy of a phone call at least 24 hours in advance to cancel or change your appointment. We reserve the right to charge for missed appointments or appointments cancelled without 24 hours advance notice. _____(please initial)

I have read and fully understand the financial policy for Alpine Dermatology Associates.
Signature: _____ Date: _____

Alpine Dermatology Associates, P.L.L.C.

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):____

   _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name: _____ Phone: _____

   Name: _____ Phone: _____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if <u>other than your home</u>: _____

   _____

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL." (Circle response)

   YES NO

5. Please write the telephone number where you want to receive calls about your appointments, lab results, or other health care information if other than your home phone number*:

   _____

   **I am fully aware that a cellular phone is not a secure and private line.*

6. Can confidential messages be left on your telephone answering machine? (Circle response)

   YES NO

7. I am fully aware that my health information can be transmitted by electronic transmission, by fax transmittal, by Internet, or by e-mail.

PATIENT
SIGNATURE: _____ DATE:_____
(Guardian if under age 18 years)

-DOCTOR-
DARNELL L. MARTIN-WIMMER, M.D., F.A.A.D.
DERMATOLOGY SPECIALIST
Alpine Dermatology Associates, P.L.L.C.

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Dr. Darnell Martin-Wimmer. I hereby acknowledge receipt of Alpine Dermatology Associates Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Alpine Dermatology Associates Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED Date:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits to the undersigned physician or supplier for these services and all future claims. X	I authorize the release of any medical information necessary to process this claim and all future claims. X

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial _____ Nickname: _____

Address: _____ City, State. Zip: _____

Sex (circle one) Male Female Date of Birth: _____/_____/_____ Age: _____ Is the Patient: Single Married Widowed Separated Divorced

Last 4 of SSN _____ Phone: (_____) _____ - _____ Cell Phone (_____) _____-_____

Employer: _____ Occupation:_____

Work Address: _____ City, State, Zip: _____

Is the Patient a Student? (circle one) Yes No If YES, name of school: _____

If you are married, please complete Spouse information below.

Spouse's Last name: _____ First name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Is Spouse currently employed? (circle one) Yes No

Employer: _____ Occupation:_____

REFERRING PHYSICIAN

Who is the Patient's Referring Physician? Name: _____ Phone: _____

Is the Patient's Primary Care Physician the same? (circle one) Yes No

If No, PCP Name: _____ Phone: _____

NEXT OF KIN INFORMATION

Give the name of nearest relative or a close friend not living with you to contact in case of an emergency.

Name: _____ Phone: _____ Relationship: _____