Radiant Complexions Dermatology Clinics

Patient Information Form

Iowa Dermatology Clinic

Last Name		First Name & Middle Initial		
Street Address		PO Box or Apt #		
City & State	Zip Code	Home Phone		Work Phone
Social Security #	Birth Date	Age	Sex	Cell Phone
E-mail Address	Employer		Parent / Guardian Name	
Referring Doctor	Family Doctor		Is Patient in a Hospice? ☐ Yes ☐ No	
Preferred Language:	Ethnicity: ☐ **Decline to Answer** ☐ Hispanic or Latino ☐ Not Hispanic Or Latino			
Race: ☐ Decline to Answer ☐ White ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander				
How Did You Hear About Us? ☐ Friend and Family ☐ Referring Doctor ☐ Google or Web Search ☐ Print Advertising ☐ Insurance Company ☐ Yellow Pages ☐ Event or Skin Cancer Screening ☐ Other (Please Explain) _____ ☐ Facebook or Social Media				

Release of Information

In the event that Radiant Complexions Dermatology Clinic, Iowa Dermatology Clinic PLC, or Radiant Pathology is unable to reach me by phone, I authorize the release of information regarding appointments, surgery times or pathology / lab results to:

___ I do not authorize release of information to anyone except me personally.
___ I authorize release of information regarding office appointments, surgery times and pathology/lab results to:

Name: _____ Relationship: _____ Phone Number: _____

_____ I give permission to leave a message on my answering machine. _____ I give permission to contact me at the e-mail address above.

DATE: _____ SIGNATURE: _____

Authorizations

_____ **Intital** **Authorization to release information:** I authorize the release of any information necessary to process my insurance. I also authorize the release of any information acquired in the course of my examination or treatment to any other physician(s) involved in my case.

Authorization to Pay Benefits: (Please acknowledge and initial all three below)

_____ **Intital** I authorize my insurance to pay Iowa Dermatology Clinic PLC d/b/a Radiant Complexions Dermatology and/or Radiant Pathology directly for all medical and/or surgical charges.

_____ **Intital** I understand that it is my responsibility to understand the medical benefit provided by the insurance plan to which I subscribe.

_____ **Intital** I understand that Iowa Dermatology Clinic PLS d/b/a Radiant Complexions Dermatology Clinic and/or Radiant Pathology cannot reduce my financial responsibility for charges applied to coinsurance, copayment or deductible or any other out of pocket amounts.

Insurance Authorization

_____ **Intital** I understand that this is a lifetime signature authorization. _____ Insurance Subscriber Name _____ Date of Birth

DATE: _____ SIGNATURE: _____

English
Iowa Dermatology Clinic PLC d/b/a Radiant Complexions Dermatology Clinic and/or Radiant Pathology complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-204-2813.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-204-2813.

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Patient Name: _____

Medical History Form

Iowa Dermatology Clinic

Please mark any of the following medical conditions that you currently have:

- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Atrial Fibrillation (Irregular Heartbeat)
- ○ Bone Marrow Transplant
- ○ BPH
- ○ Breast Cancer
- ○ Colon Cancer
- ○ COPD
- ○ Coronary Artery Disease
- ○ Depression
- ○ Diabetes
- ○ End Stage Renal Disease
- ○ GERD
- ○ Other: _____
- ○ Hearing Loss
- ○ Hepatitis
- ○ Hypertension
- ○ HIV/AIDS
- ○ Hypercholestrolemia
- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Leukemia
- ○ Lung Cancer
- ○ Lymphoma
- ○ Prostate Cancer
- ○ Radiation Treatment
- ○ Seizures
- ○ Stroke
- ○ Acne

Date of Birth:_____

Date of Service: _____

Have you had any of the following skin conditions:

- ○ Acne
- ○ Actinic Keratosis
- ○ Asthma
- ○ Basal Cell Skin Cancer
- ○ Blistering Sunburns
- ○ Dry Skin
- ○ Eczema
- ○ Flaking or Itchy Scalp
- ○ Hay Fever/Allergies
- ○ Melanoma
- ○ Poison Ivy
- ○ Precancerous Moles
- ○ Psoriasis
- ○ Squamous Cell Skin Cancer
- ○ Other: _____

Do you wear sunscreen? ○ Yes ○ No
Do you use tanning beds? ○ Yes ○ No
Family history of melanoma? ○ Yes ○ No

Please list any surgeries you have had in the past:

_____

_____

_____

Please list all allergies:

_____

_____

_____

Please list your current medications (or provide list):

_____

_____

_____

_____

_____

_____

Smoking Status? ○ Current ○ Former ○ Never
Alcohol Use? ○ Yes ○ No
If yes, # of drinks/day ○ 0 ○ 1 ○ 2 ○ 3+
Family History of any of the following?
○ Acne ○ Eczema ○ Psoriasis ○ Skin Cancer

Primary Care Provider Name: _____
Preferred Pharmacy: _____
Pharmacy Location: _____

Reason for Visit Today: _____

Please mark any condition below that you are currently experiencing:

Skin
- ○ Rash
- ○ Dry Skin
- ○ Itching
- ○ Change in Mole(s)
- ○ Hives
- ○ Open Wound
- ○ Wart
- ○ Eczema
- ○ Psoriasis
- ○ Cyst
- ○ Problems w/ Healing
- ○ Problems w/ Scarring
- ○ Problems w/ Bleeding
- ○ Acne

Constitutional
- ○ Fever
- ○ Chills
- ○ Runny Nose

Endocrine
- ○ Diabetes
- ○ Thyroid Problems

Musculoskeletal
- ○ Muscle Weakness
- ○ Joint Aches

ENMT
- ○ Sore Throat

Eyes
- ○ Blurry Vision

Neuro
- ○ Headaches
- ○ Seizures

GI
- ○ Nausea
- ○ Diarrhea
- ○ Abdominal Pain

Cardiovascular
- ○ Chest Pain
- ○ Dizziness
- ○ Light Headed

Psych
- ○ Depression
- ○ Anxiety

GU
- ○ Difficult Urination
- ○ Painful Urination
- ○ Incontinence

Respiratory
- ○ Cough
- ○ Shortness of Breath
- ○ Wheezing

Hem/Lymph
- ○ Tender lymph nodes

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Patient Name: _____

Patient Privacy Information Form

SUMMARY OF PRIVACY PRACTICES & PATIENT ACKNOWLEDGEMENT FORM

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. The full version is available at our front desk. Copies can be made as requested.

Date of Last Revision: August 12, 2015
Effective Date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- For workers' compensation programs

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

I am a patient of Iowa Dermatology Clinic, PLC; Radiant Complexions Dermatology Clinic or Radiant Pathology. I hereby acknowledge receipt of this Notice of Privacy Practices.

Signature: _____

Patient's Name: _____

Date: _____ Relationship to Patient (if patient is under 18 years old): _____

If patient refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

Signature (name and title): _____

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