**PATIENT MEDICAL HISTORY**

**(If you have completed this information in the Patient Portal, please inform one of our Front Office Team Members)**

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the reason for your visit?** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you currently have or ever had the following diseases or conditions listed: (Please check if any applicable)

* Anxiety
* Arthritis
* Asthma
* Irregular heartbeat
* Bone Marrow Transplant
* Transplant
* Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Treatment of cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* COPD
* Coronary Artery Disease
* Depression
* Diabetes
* Renal Disease
* GERD
* Hearing loss R L (circle one)
* Hepatitis A B C (circle one)
* Hypertension
* HIV/ AIDS
* Hypercholesterolemia
* Hyperthyroidism
* Hypothyroidism
* Radiation Treatment
* CLL
* Seizures
* Stroke
* Autoimmune disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any other medical conditions or diagnoses (not listed above)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list surgical procedures/hospitalizations and dates (including skin cancer treatment)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Actinic Keratoses
* Basal Cell Skin Cancer
* Squamous Cell Skin Cancer
* Melanoma
* Blistering Sunburns
* Dry Skin
* Eczema
* Hay Fever/Allergies
* Tanning bed use
* Wears sunscreen
* Precancerous Moles (MILD, MODERATE, SEVERE)
* Psoriasis

Have you had any moles removed?  **YES**  **No** If **YES**, what was the diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of skin cancer/Melanoma?  **YES**  **No** If **YES** what type and whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

Do you take any RX medications (Including Aspirin, Birth Control, Routine Antibiotics, Over The Counter Medications & Supplements)

**YES**  **NO**

**If YES, please list:**

Medication

Dosage

How often RX is taken

Start Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you allergic to any medications?**  **YES**  **NO** If **YES**, please list medication AND the reaction**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**ALCOHOL USE**

* Less than 1 drink per day
* 1-2 Drinks Per Day
* 3+ Drinks Per Day
* NONE

**TOBACCO USE**

**(CHEWING AND SMOKING)**

* Current User – How much/often per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Former User
* Never A User

**DRUG USE**

* Current User \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Former User
* Never A User

**Women**

* Pregnant
* Planning a pregnancy
* Currently Nursing

**PATIENT or LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FLATIRONS DERMATOLOGY PLLC**

**PATIENT INFORMATION**

**Power of Attorney (if applicable, please indicate who has POA)**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex/Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apartment or Unit #: \_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

**(IF PATIENT IS UNDER THE AGE OF 18)** Name of Parent or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB of Parent or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the billing address the same as the patient? [ ] Yes [ ] No

**Emergency Contact**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**If you have completed this information in the patient portal, please inform one of our Front Office Team Members.**

**FLATIRONS DERMATOLOGY ANNUAL PAPERWORK**

(To be completed yearly by **ALL** patients)

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF YOUR PRIMARY CARE PHYSICIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN PHONE NUMBER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY NAME, PHONE NUMBER, & CITY**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the preferred phone number(s) to call you regarding any financial, insurance, or medical information:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** May we leave a voice message? **[ ] YES [ ] NO**

Are there any family member(s) we can speak to regarding your medical information? **[ ] YES [ ] NO**

If **YES**, please give name(s) and relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT CLINICAL DIAGNOSIS AND TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby give consent to the clinical staff of **Flatirons Dermatology** to examine, treat, and counsel me. I understand there are certain hazards and risks connected with all forms of treatment and my consent is given with this knowledge.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH INFORMATION CONSENT AND PATIENT PORTAL**

**My Authorization (PLEASE CHECK ONE)**

[ ] You may disclose non-urgent and benign medical results to me via the secure online medical records portal.

[ ] You may **NOT** disclose non-urgent and benign medical results to me via the secure online medical records portal.

I may revoke this authorization in writing. If I revoke this authorization, it does not affect any actions taken by **Flatirons Dermatology** based upon this authorization.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed a copy of **Flatirons Dermatology** Notice of Privacy Practice Information Form. I also acknowledge that if I would like a copy of the Notice of Privacy Practice Information Form that I will request one from Flatirons Dermatology Front Desk Team.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT FINANCIAL RESPONSIBILITES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed **Flatirons Dermatology Patient Financial Responsibilities** Policy and agree to all terms. I also acknowledge that if I would like a copy of the Patient Financial Responsibilities that I will request one from Flatirons Dermatology Front Desk Team.  I hereby authorize Flatirons Dermatology and its employees, agents, and assignees to contact me via e-mail and text messaging, and to my cellular devices.

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

A picture containing shape

Description automatically generated

Christopher M. Smith, MD

Chante K. Aksut, MD

Wendy R. Ortiz, PA-C

Ben R. Kochman, PA-C

**\*FOR OFFICE USE ONLY\***

PATIENT INFORMATION

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_  
Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO / FROM FLATIRONS DERMATOLOGY

(This release expires 1 year from the date of signature or upon written notification)

I hereby authorize the release of information from my medical records as indicated below.

Records released TO / FROM

Physician/Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records released TO / FROM

Flatirons Dermatology

13605 Xavier Lane, Suite B

Broomfield, CO 80023

Phone: (303) 404-3376

Fax: (303) 468-8793

THE TYPE OF INFORMATION TO BE DISCLOSED AS FOLLOWS:

\_\_\_\_\_\_\_All Information in chart \_\_\_\_\_\_\_Laboratory Reports

\_\_\_\_\_\_\_Financial Information \_\_\_\_\_\_\_Pathology and associated Procedure Reports

\_\_\_\_\_\_\_Medical Information \_\_\_\_\_\_\_Substance abuse if any

I request and authorize the release of information to/from the organization, agency, or individual name above. I understand that the information to be released may include the following condition(s). Drug abuse/alcohol abuse (Fed. Reg.42 C.F.R, Part 20). Psychological or psychiatric conditions/HIV antibody test which causes AIDS. An AIDS diagnosis and/or and AIDS related condition/third party source receive treatment from Flatirons Dermatology. I understand that any disclosure of information carries with it the potential for and unauthorized re-disclosure of information may not be protected by federal confidential rules. I have a right to revoke the authorization in writing to Flatirons Dermatology.

I UNDERSTAND THERE MAY BE A CHARGE FOR THIS SERVICE ACCORDING TO COLORADO STATUTE (6CCR 1101-1, RULE XIV). $18.00 for the first 10 pages, $0.85 pages 11-39 and $0.57 for pages 41 and above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Agent / Guardian Signature Date