PATIENT MEDICAL HISTORY

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

| ATIENT NAME | DATE OF BIRTH | | | |
|--|---|---|--|--|
| What is the reason for your visit? | | | | |
| | e following diseases or conditions listed: (Please check if any applicable) SKIN CONDITIONS: | | | |
| NONE | ☐ Hay Fever / Allergies / Asthma | ☐ NONE | | |
| Anxiety / Depression | Hearing loss R L (circle one) | Actinic Keratoses | | |
| Autoimmune | Hepatitis A B C (circle one) | Basal Cell Skin Cancer | | |
| disorder | HIV/ AIDS | | | |
| Bone Marrow or Organ Transplant | | Eczema | | |
| 0 30 TO 100 TO 1 | High Cholesterol | Melanoma | | |
| Cancer_ | ☐ Hyper / /Hypothyroidism | Precancerous Moles (MILD, | | |
| COPD | ☐ Irregular Heartbeat | MODERATE, SEVERE) | | |
| Coronary Artery Disease / High | Radiation Treatment | Psoriasis | | |
| Blood Pressure | Renal Disease | Squamous Cell Skin Cancer | | |
| Diabetes | Seizures / Stroke | ☐ Tanning bed use | | |
| ☐ GERD | Scizures / Stroke | Wears sunscreen | | |
| Any other medical conditions or diagn | oses (not listed above): | , | | |
| Are you allergic to any medications? [| ☐ YES ☐ NO / NONE If YES, please I | ist medication AND the reaction: | | |
| | | | | |
| | | | | |
| | | eatment). | | |
| Please list surgical procedures/hospital | lizations and dates (including skin cancer th | catificity. | | |
| Please list surgical procedures/hospital | nizations and dates (including skin cancer to | catherry. | | |
| | cer/Melanoma? \(\sum \text{YES} \text{No} \text{If YE} | | | |
| Do you have a family history of skin can | cer/Melanoma? □ YES □ No If YE ★ MEDICATIONS ★ S □ NO / NONE (Including Aspirin, Birth Control | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications YEstupplements If YES, please list: | cer/Melanoma? □ YES □ No If YE <u>★ MEDICATIONS ★</u> S □ NO / NONE (<u>Including Aspirin, Birth Control</u> | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications If YES, please list: | cer/Melanoma? □ YES □ No If YE <u>★ MEDICATIONS ★</u> S □ NO / NONE (<u>Including Aspirin, Birth Control</u> | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications YE Supplements If YES, please list: | cer/Melanoma? □ YES □ No If YE MEDICATIONS ★ S□ NO / NONE (Including Aspirin, Birth Control ge How often RX | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications YEstupplements If YES, please list: | cer/Melanoma? □ YES □ No If YE MEDICATIONS ★ S□ NO / NONE (Including Aspirin, Birth Control ge How often RX | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications YEstupplements) If YES, please list: Medication Dosa | cer/Melanoma? ☐ YES ☐ No If YE ** MEDICATIONS ** S ☐ NO / NONE (Including Aspirin, Birth Control ge How often RX | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications YE upplements) If YES, please list: Medication Dosa | cer/Melanoma? □ YES □ No If YE ** MEDICATIONS ** S□ NO / NONE (Including Aspirin, Birth Control ge How often RX | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications YE supplements) If YES, please list: Medication Dosa Are you allergic to latex? YES N | cer/Melanoma? ☐ YES ☐ No If YE ** MEDICATIONS ** S ☐ NO / NONE (Including Aspirin, Birth Control ge How often RX | S what type and whom? | | |
| Do you have a family history of skin can Do you take any RX medications YE supplements) If YES, please list: Medication Dosa TOBACCO USE | MEDICATIONS ★ S □ NO / NONE (Including Aspirin, Birth Control ge How often RX NO ★ SOCIAL HISTORY ★ | S what type and whom? I. Routine Antibiotics, Over The Counter Medication is taken Start Date | | |
| Do you have a family history of skin can Do you take any RX medications YE upplements) If YES, please list: Medication Dosa TOBACCO USE (CHEWING AND SMOKING) | MEDICATIONS ★ S □ NO / NONE (Including Aspirin, Birth Control ge How often RX NO ★ SOCIAL HISTORY ★ ALCOHOL USE | S what type and whom? I. Routine Antibiotics, Over The Counter Medication is taken Start Date DRUG USE | | |
| Do you have a family history of skin can Do you take any RX medications YE upplements) If YES, please list: Medication Dosa TOBACCO USE (CHEWING AND SMOKING) Current User – How | MEDICATIONS ★ S□NO/NONE (Including Aspirin, Birth Control ge How often RX NO ★ SOCIAL HISTORY ★ ALCOHOL USE □ Less than 1 drink per day | S what type and whom? I. Routine Antibiotics, Over The Counter Medication is taken Start Date | | |
| Do you have a family history of skin can Do you take any RX medications YEstapplements If YES, please list: Medication Dosa Are you allergic to latex? YES N TOBACCO USE (CHEWING AND SMOKING) | MEDICATIONS ★ S□NO / NONE (Including Aspirin, Birth Control ge How often RX ALCOHOL USE □ Less than 1 drink per day □ 1-2 Drinks Per Day | S what type and whom? I. Routine Antibiotics, Over The Counter Medication is taken Start Date DRUG USE Current User | | |
| Do you have a family history of skin can Do you take any RX medications YE Supplements If YES, please list: Medication Dosa Are you allergic to latex? YES N TOBACCO USE (CHEWING AND SMOKING) Current User – How | MEDICATIONS ★ S□NO/NONE (Including Aspirin, Birth Control ge How often RX NO ★ SOCIAL HISTORY ★ ALCOHOL USE □ Less than 1 drink per day | S what type and whom? I. Routine Antibiotics, Over The Counter Medication is taken Start Date DRUG USE | | |

★Women /Patients with childbearing potential (F)

o Pregnant
Patient Packet Rev 02-26-2025

o Planning a pregnancy

o Currently Nursing



Christopher M. Smith, MD Wendy R. Ortiz, PA-C Ben R. Kochman, PA-C Cassandra Ho, PA-C

| | *FOR OFFICE USE ONLY* | * | | | | |
|--|---|--|--|--|--|--|
| PATIENT INFORMATION | | | | | | |
| Last Name: | First Name: | First Name: | | | | |
| DOB: | - 1. I.O. I.O. 1. D. D. D. B. | | | | | |
| Street Address: | | | | | | |
| City: | State: | Zip Code: | | | | |
| City: Home Phone: | Cell Phone: | | | | | |
| AUTHORIZATION TO RELEASE DERMATOLOGY | HEALTHCARE INFORMATION | TO / FROM FLATIRONS | | | | |
| (This release expires 1 year from the I hereby authorize the release of information of the Page 14 and 170 (FROM) | | | | | | |
| Records released TO / FROM Physician/Clinic Name: | | | | | | |
| Address: | | | | | | |
| City: | State: | 7in: | | | | |
| City:Phone: | Fax: | <u> </u> | | | | |
| Records released TO / FROM | | | | | | |
| Flatirons Dermatology | | | | | | |
| 13605 Xavier Lane, Suite B | | | | | | |
| Broomfield, CO 80023 | | | | | | |
| Phone: (303) 404-3376 | | the second section of the section of th | | | | |
| Fax: (303) 468-8793 | | | | | | |
| 1 ax. (303) 406-8733 | | | | | | |
| THE TYPE OF INFORMATION T | O BE DISCLOSED AS FOLLOWS | S: | | | | |
| | Laboratory Reports | | | | | |
| Financial Information | Financial InformationPathology and associated Procedure Reports | | | | | |
| Medical Information | cal Information Substance abuse if any | | | | | |
| understand that the information to be abuse (Fed. Reg. 42 C.F.R, Part 20). AIDS. An AIDS diagnosis and/or at Flatirons Dermatology. I understand unauthorized re-disclosure of information in writing to UNDERSTAND THERE MAY BE | be released may include the following Psychological or psychiatric condition of AIDS related condition/third pared that any disclosure of information mation may not be protected by federate to Flatirons Dermatology. E A CHARGE FOR THIS SERVICE. | tions/HIV antibody test which causes ty source receive treatment from carries with it the potential for and eral confidential rules. I have a right to | | | | |

Date

Patient / Agent / Guardian Signature

Patient Packet Rev 02-26-2025

FLATIRONS DERMATOLOGY

CONSENT FOR 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 |
|--|
| examine, treat, and counsel me. I understand there are certain hazards and risks connected with all forms of freatment and my consent is given with this knowledge |
| |
| INITIAL: |
| 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: |
| 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 |
| 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 understand that responsibility for exament of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to the provider. I authorize the submission of claims without obtaining my signature or each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed reatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare information Portability and Accountability Act of 1996. 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. |
| Patient Signature: Date: |

FLATIRONS DERMATOLOGY PLLC

FLATIRONS DERMATOLOGY ANNUAL PAPERWORK

(To be completed yearly by ALL patients)

PATIENT INFORMATION

| First Name: | Middle Initial: | Last Name | e: | | | |
|---|---------------------|--------------------|--------------------------|--|--|--|
| 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: | | | | | | |
| Power of Attorney (if applicable, please indicate who has POA) Name: | | | | | | |
| | | | | | | |
| Phone: | | | | | | |
| | | | | | | |
| NAME OF YOUR PRIMARY CARE | PHYSICIAN | | | | | |
| PRIMARY CARE PHYSICIAN PHONE NUMBER | | | | | | |
| DUADMACY NAME DUONE NUM | DED & CITY | | | | | |

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