GALT DERM

Patient Intake Form

Please take a moment to fill out our online intake form before your visit. This will help save you time and avoid spending additional time in the waiting room. ***You will only be asked to update this information once every three years.*** All information is kept completely confidential in our HIPAA compliant system.

Full Name _____

Preferred Name _____ Email _____

Please provide at least one phone number. Your mobile number can be used to look up your account and receive text message appointment reminders.

Phone: Mobile _____ Home _____ Work _____

Home Address _____

Date of Birth _____Gender _____ Sex _____SSN _____

Preferred Pharmacy _____

Pharmacy Phone _____ Pharmacy Address _____

Guardian _____

Guardian Phone _____ Guardian Relationship _____

Emergency Contact _____

Emergency Phone _____Emergency Relationship _____

Family Doctor _____

Family Doctor Phone _____Family Doctor Email _____

Name of referring professional _____

Referring phone _____Referring email _____

Occupation _____ Employer _____

How did you hear about us? _____

Name of previous dermatologist? _____

I would like to receive discounts, special promotions, and news by email. Yes No

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Personal Medical History or Current Problem With Any of the Following?

- Acne
- Angina / Heart Attack / Cardiac Stent
- Anxiety
- Arthritis
- Artificial Joints
- Asthma
- Atopic Dermatitis (Eczema)
- Autoimmune Condition
- Bladder Problems
- Clotting Disorder
- Cough
- Crohn's / Colitis
- Celiac Disease
- Connective Tissue Disease
- Diabetes
- Depression
- Emphysema / Chronic Bronchitis
- Gastric-Esophageal Reflux (GERD)
- Hay Fever / Allergies
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Heart Valve Problem
- Heart Rhythm Problem
- HIV
- Immunosuppression
- Internal Malignancy (Cancer)
- Kidney Problems
- Liver Disease
- Lung Disease
- Lupus
- Multiple Sclerosis
- Problems with bleeding
- Problems with healing
- Problems with scarring (hypertrophic or keloid)
- Psoriasis
- Radiation Treatment History
- Rosacea
- Seizures
- Stomach / Duodenal Ulcers
- Stroke
- Thyroid Disorder
- Transplant
- Tuberculosis
- N/A - No Prior Medical History

Have You Had Any of the Following Skin Conditions?

- Atypical Moles / Precancerous Moles
- Actinic Keratosis
- Basal Cell Carcinoma
- Blistering Sunburns
- Squamous Cell Carcinoma
- Melanoma - Personal History
- Melanoma - Family History
- Tanning Bed Use
- None / Not Applicable to me

Please List Any Allergies _____

_____

_____

Are You Currently Taking Any Blood Thinners?

- NONE
- Aspirin
- Cilostazol (Pletal)
- Coumadin (Warfarin)
- Dipryidamole (Aggrenox)
- Effient
- Eliquis
- Pentoxyfylline (Trental)
- Plavix (Clipidogrel)
- Pradaxa
- Ticagrelor (Brilinta)
- Ticolodipin (Ticlid)
- Xarelt

I certify that the above medical information is correct to my knowledge. _____

Name _____ Date _____

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Privacy and Sharing of Information

We are required by law to provide you with a notice that explains our privacy practices concerning your medical information. This notice describes how we may use and disclose your protected health information for treatment, payment, and health care operations, as well as for other purposes that are permitted or required by law. Please refer to our website or inquire at the front desk for a copy of our Privacy Notice

_____ I have reviewed the Notice of Privacy Practices.

Scheduling, Financial, & Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the physicians' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee. Please refer to our website or inquire at the front desk for a copy of our Scheduling, Financial, and Cancellation Policy

_____ I acknowledge that I have had sufficient time to read, understand, ask questions, and agree to the Scheduling, Financial, and Cancellation Policies

Authorization and Consent for Use and Disclosure of Photography

I hereby authorize and consent to take, use, and disclose photographs and video of me to patients, prospective patients, and such individuals as may be necessary for marketing and educational purposes. I hereby waive all claims for compensation or damage for such use and disclosure that are consistent with this authorization. I understand that I am under no obligation to provide my authorization and that my treatment, payment, or care will not be impacted in any way by my refusal to provide such authorization.

_____ I agree and acknowledge that I have had sufficient time to read, understand, and ask questions to the authorization above.

_____ I disagree with the authorization above.

Communication Policy

I hereby consent to the following: Reminders of upcoming scheduled appointments with Galt Dermatology may be left on your voicemail or answering machine or with a friend or family member who answers at a number you have provided, and/or sent via email, text message, mail, or postcard to your home address.

Notification regarding the availability and results of pathology or laboratory results may also be left on your voicemail/answering machine or communicated with a friend or family member who answers the telephone at the number you provide (at the doctor's sole discretion).

If you provided a cell phone number in your contact information, Galt Dermatology's first attempt to contact you will be via cell phone and, if needed, Galt Dermatology may leave a message (including, without limitation, voicemail and text message).

Certain dermatological conditions can be life-threatening. If this is the case we will do everything in our power to ensure you receive proper care, however, this requires open communication between you and the practice. After repeated attempts to contact you without acknowledgment, we may send a certified letter via the most recent address we have on file which may include dismissal from our care for non-compliance.

_____ I agree and acknowledge that I have had sufficient time to read, understand, and ask questions about the policy above.

Signature _____

Name _____ Date _____