Dillon Dermatology
Patient Information Form

PLEASE PRINT!!!!!!!

Name _____ _____ _____
(Last) (First) (M.I.)

Address _____ City _____State ____ Zip Code _____

Home Phone (_____)_____ Cell (_____)_____ Age____ D.O.B. ___/___/___

Male or Female _____ Marital Status(circle) M S W D

Employment _____ Social Security Number _____

Work Phone Number (_____)_____ May we call you at work? _____

P.O.A. or Guardian _____ Phone Number (_____)_____

Address _____ City _____State ____ Zip Code _____

Family Physician _____ Phone Number (_____)_____

Address _____ City _____State ____ Zip Code _____

Insurance Co. _____ Policy Holder _____

Policy Holder Relation to Patient _____ Policy Holder D.O.B. ___/___/_____

Whom may we contact in an emergency? _____

Emergency Contact Phone Number (_____)_____

Whom may we thank for referring you to us? _____

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier. I will be responsible for any amount not covered by insurance or for any amount not covered by insurance for any visit made without a referral on file from my primary care physician if required.

Signature _____ Date ___/___/_____

PLEASE HAVE YOUR DRIVER'S LICENSE AND INSURANCE CARDS AVAILABLE SO THEY MAY BE COPIED FOR THE OFFICE RECORDS.

Dillon Dermatology
Notice of Privacy Practices Acknowledgement

I, _____, hereby acknowledge that on ___/___/_____
(Printed Name) (Today's Date)
I was offered a copy of the Notice of Privacy Practices of Dillon Dermatology, which sets forth the ways in which my personal health information may be used or disclosed by Dillon Dermatology and outlines my rights with respect to such information. I understand that I may request from Dillon Dermatology a copy of the Notice of Privacy Practices at any future time.

I permit Dillon Dermatology to discuss my private health information with, and to disclose my private health information to the following individuals:

	First Name	Last Name	Phone Number	Relation to Patient
1			( )	
2			( )	
3			( )	
4			( )	
5			( )	
6			( )	
7			( )	

☐ None

Printed Name _____ _____
(First Name) (Last Name)

Signature _____ Date ___/___/_____

Above Signature is:

☐ Patient's Signature

☐ Guardian's Signature

Dillon Dermatology, INC.
Patient History Form

PLEASE PRINT!!!!!!!

Patient Name _____ Date ___/___/_____

Nature of the Problem _____

How long has this been present? Please fill in a number:

_____Days _____Weeks _____Months _____Years

Location of problem: _____

Symptoms (check all that apply) ____Itching ____Tenderness ____Swelling ____Heat ____Redness

Severity (check one) _____Mild _____Moderate _____Severe

Does anything make this problem better or worse? _____

Are you Pregnant? _____ Yes _____ No _____ Maybe

List the names of any medication you take (prescription or over-the-counter):

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Do you take _____ Aspirin _____ Coumadin _____ Plavix _____ Vitamin E _____ Garlic?

List any medication allergies you have:

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

Do you have a(n) _____artificial joint(s) _____artificial heart valve _____cardiac defibrillator?

Do you smoke? ___Yes ___ No. Do you drink alcohol? ___ Yes ___ No. How many drinks per week? _____

Does anyone in your family have a history of Melanoma? _____Yes _____ No

Any other skin diseases that run in the family? (list): _____

_____

Have you ever had a skin cancer? (list type and location) Type: _____ Location: _____

Medical/Surgical problems (please check any that apply):

- ☐ High blood pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Valve Disease
- ☐ Diabetes
- ☐ Heart Failure
- ☐ Bleeding Problems
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Hepatitis
- ☐ Kidney Failure
- ☐ Cancer
- ☐ Emphysema
- ☐ Asthma
- ☐ Weight Loss
- ☐ Fever (recently)
- ☐ Pacemaker
- ☐ Tuberculosis
- ☐ Positive TB Skin Test
- ☐ Lupus
- ☐ Sun Sensitivity
- ☐ HIV Positive
- ☐ Psychiatric Problems

Are there any other important medical problems that we should know about? (list):

_____

_____

Signature _____ Date ___/___/_____

Dillon Dermatology
Notice of Privacy Practices

The terms of this *Notice of Practices* apply to Dillon Dermatology

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this *Notice of Practices* as necessary and to make a new *Notice* effective for all personal health information maintained by us. You may receive a copy of any revised *Notices* at this location or request a copy to be mailed.

Uses and Disclosures of Your Personal Health Information

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that consent or authorization in writing unless we have taken any action in reliance on the consent or authorization.

Uses and Disclosures for Treatment. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal health information to another healthcare facility or professional who is not affiliated with our practice but who is or will be providing treatment to you.

Uses and Disclosures for Health Care Options. We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which include clinical improvement, professional peer review, business management etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your personal health information to another healthcare facility, healthcare professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Family and Friends Involved in Your Care. With your approval, we may from time to time, disclose your personal health information to designated family, friends and others who are involved in your personal care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components or our services are performed through contracted with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain amounts of your personal health care information to one or more of these outside persons or organizations that assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services. We may contact you to provide appointment reminders or test results. You have the right to request, and we will accommodate reasonable requests by you, to receive communication regarding your personal health information from us by alternative means or at alternative locations.

Health Products and Services. We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, advise you of new products and services we offer, and to provide general health and wellness information.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a researcher may wish to compare the outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the research that limit their use and disclosure of patient information.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- We may release your personal health information for any purpose required by law;
- We may release your personal health information for public health activities, such as required reporting of disease, injury, birth and death, and for required public health investigations;
- We may release your personal health information as required by law if we suspect child abuse or neglect. We may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect or domestic violence;
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in drug recalls;
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer, in most cases you will receive notice that information is disclosed to your employer;
- We may release your personal health information if required by law to a government oversight agency conducting audits investigations, or civil or criminal proceedings;
- We may release your personal health information if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such release;
- We may release your personal health information to law enforcement officials as required by law to report wounds, injuries and crimes;
- We may release your personal health information to coroners and/or funeral directors consistent with law;
- We may release your personal health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities;
- We may release your personal health information to workers compensation agencies if necessary for your workers' compensation benefit determination.

Rights That You Have

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. You may obtain an access request form from the Privacy Officer.

Amendments to Your Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain this form from the Privacy Officer.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive accounting of certain disclosures made by us for your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Privacy Officer.

Restrictions on Use and Disclosure of your Personal Health Information. You have the right to request restrictions on certain uses and disclosures of your personal health information for treatment, payment or health care operations. A restriction request form can be obtained from the Privacy Officer.

Complaints. If you think that we have violated your privacy rights, or you disagree with a decision we made about your health information, you may file a complaint with the Privacy Officer as listed below.

Person to Contact for Information About This *Notice*. If you have any questions about this *Notice* or any complaints about our privacy practices, please contact:

Dillon Dermatology
Attn: Privacy Officer
1103 Village Square Drive, Suite 205
Perrysburg, Ohio 43551

Or

Dillon Dermatology
Attn: Privacy Officer
1037 Conneaut Avenue, Suite 201
Bowling Green, Ohio 43402