Alpine Dermatology Associates, P.L.L.C.

1785 Kipling St.
Lakewood, Colorado 80215
(303) 935-4681

MEDICAL HISTORY

Patient Name ____ Date ___________________

Are you allergic to any medications? Yes/No If yes, please list:

1.
2.
3.
4.

LIST ALL MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBAL) YOU ARE CURRENTLY TAKING:

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

HISTORY OF MEDICAL PROBLEMS

Do you have or have you ever had problems with…Circle (Y)es or (N)o:

Systemic

Diabetes ....Y N
Thyroid ....Y N
Kidney/urinary tract ....Y N
Stomach ....Y N
Bowels/gall bladder ....Y N
Liver/spleen/hepatitis ....Y N
Allergies/hay fever/sinus ....Y N

Seizures/epilepsy ....Y N
Fainting ....Y N
Glaucoma/eyes ....Y N
Alcoholism.....................................Y N
AIDS exposure ....Y N
Phlebitis ....Y N
Arthritis..Y N

Lungs

Asthma ....Y N
Emphysema ....Y N
Bronchitis.....................................Y N
Morning cough ....Y N
Chronic cough ....Y N
TB/clots in lungs ....Y N

Vascular

High blood pressure.......................Y N
Chest pain ....Y N
Heart attack....................................Y N
Heart murmur.................................Y N
Irregular/fast heart beat ....Y N
Pacemaker ....Y N

Other: ____

Reviewed by: ____ Date: _____________________

Darnell Martin-Wimmer, M.D.

Patient Name ____________________________

FAMILY HISTORY OF MEDICAL DISEASES

Cancer..Y N
High blood pressure....................Y N
Heart disease..............................Y N
Stroke...Y N

Arthritis..Y N
Diabetes...Y N
Allergy/hay fever/sinus...................Y N
Family history of skin diseases.......Y N

Other: ____

LIST PAST SURGERIES AND APPROXIMATE TIME/AGE

____

____

PLEASE ANSWER THE FOLLOWING

1. Do you smoke/chew tobacco?..........Y N How much? ___________________________________
2. Do you use recreational drugs?.........Y N Which drug(s)? ________________________________
3. Do you bleed easily/aspirin................Y N
4. Any artificial joints?............................Y N Where? ______________________________________
5. **Women:**

   Are you pregnant?............................Y N Due date ________________________
   Breast feeding?................................Y N
   Are you on the Pill?..........................Y N Depoprovera shots? Y N Estrogen? Y N
   Progesterone?.................................Y N

SKIN HISTORY

1. Where did you grow up?______________________________ Were you a lifeguard? Y N
2. How many blistering sunburns did you get before age 21? _____
3. Anyone in your family have skin cancer?...Y N
   - Basal cell..Y N
   - Squamous cell.....................................Y N
   - Melanoma..Y N
   - Pre cancer...Y N
4. Have you had skin cancers?......................Y N
   - Basal cell..Y N
   - Squamous cell.....................................Y N
   - Melanoma..Y N
   - Pre cancer...Y N
5. Do you have a history of skin disease?......Y N
6. Any other diseases or conditions we should know about? Please describe:

   ____
7. Do you use sunscreen regularly?...............Y N
8. Any surgery done in the past 6 months?....Y N If yes, what and when:

   ____
9. What is your occupation? ____
10. What are your hobbies?____

Completed by: ____Patient ____Other relationship _____________ ____Medical assistant

Reviewed by: ____ Date: ___________________

Darnell Martin-Wimmer, M.D.

REVIEW OF SYSTEMS

Patient Name: ________________________________ **Date of Birth** ___________________
What are we seeing you for today? ____
____

Constitutional Symptoms	**Yes**	**No**
Fever or chills	☐	☐
Excessive weight loss or gain	☐	☐
Fatigue	☐	☐
Skin		
Rashes or color changes	☐	☐
Itching or dryness	☐	☐
Hair or nail changes	☐	☐
Changing moles	☐	☐
Eyes		
Loss of vision	☐	☐
Distorted vision or haloes	☐	☐
Eye pain or soreness	☐	☐
Ears, Nose, Mouth, Throat		
Hearing difficulty	☐	☐
Ringing or dizziness	☐	☐
Sinus congestion	☐	☐
Runny nose/post-nasal drip	☐	☐
Nose bleeds	☐	☐
Dryness/hoarseness	☐	☐
Cardiovascular		
Chest pains or palpitations	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐
Endocrine		
Heat or cold intolerance	☐	☐
Excessive thirst or hunger	☐	☐

Gastrointestinal	**Yes**	**No**
Swallowing difficulty	☐	☐
Vomiting/heartburn	☐	☐
Constipation/diarrhea	☐	☐
Nausea/vomiting	☐	☐
Genito-urinary		
Urinary frequency	☐	☐
Urinary pain or blood	☐	☐
Females		
Currently pregnant	☐	☐
Breast masses or discharge	☐	☐
Vaginal bleeding/discharge	☐	☐
Pelvic pain	☐	☐
Musculoskeletal		
Joint pain, swelling, redness	☐	☐
Muscle pain or cramps	☐	☐
Neurological		
Headaches/migraines	☐	☐
Numbness or tingling	☐	☐
Weakness or paralysis	☐	☐
Fainting or blackouts	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Hematological/Lymphatics/Immunology		
Easy bruising/bleeding	☐	☐
Blood transfusions	☐	☐
Swollen lymph nodes	☐	☐

Other symptoms not listed above: ________________
____
____

Date: ___________________________
Reviewed by: Dr. Darnell Martin-Wimmer

ALPINE DERMATOLOGY ASSOCIATES
FINANCIAL POLICY

Welcome to Alpine Dermatology. In order for us to be able to deliver the quality of care that you are accustomed to, we have established these financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality of care and make your visit as pleasant as possible. **PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY INITIALING AND SIGNING BELOW.**

When asked, and as a courtesy to you, we will try to give you general guidelines about what your insurance might cover. Since medical insurance is an agreement entered into by you and your insurance carrier, **YOU ARE ULTIMATELY RESPONSIBLE FOR KNOWING THE SPECIFICS OF WHAT YOUR POLICY COVERS.**

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone numbers, please notify the receptionist and we will give you a form to update.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. My copayment for each visit is $__________. My annual deductible is $_______ of which $______ has been met for this year. If you have a balance after an insurance payment from a previous visit, we will also ask for that payment. We accept cash, checks, Visa and MasterCard .
   ______(please initial)
4. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within *60 days* of being submitted, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. You will be responsible at the time of service for payment of annual deductibles, copayments, charges for noncovered or cosmetic services*
   ______(please initial)

   ***You will be asked to sign a Waiver of Liability form in the event that service is provided which we know is not, or have reason to believe may not be, covered by Medicare.**

   ***If your insurance requires a referral for specialty care, it is your responsibility to obtain the correct referral. You will be responsible for any services rendered without the proper referral.**

5. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service. If we do not participate with your plan, we will provide you a receipt to file with your insurance company and full payment will be expected at the time of service. ______(please initial)
6. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay in full at the time of service. ______(please initial)
7. NO SHOW OR MISSED APPOINTMENTS: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not cancelled in advance, and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there *may* be time when you are unable to keep an appointment, but we ask the courtesy of a phone call at least 24 hours in advance to cancel or change your appointment. We reserve the right to charge for missed appointments or appointments cancelled without 24 hours advance notice. ______(please initial)

I have read and fully understand the financial policy for Alpine Dermatology Associates.

Signature: ____ Date: ________________________

Alpine Dermatology Associates, P.L.L.C.

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):____

   ____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name: ______________________________ Phone: __________________

   Name: ______________________________ Phone: __________________

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if <u>other</u> <u>than</u> <u>your</u> <u>home</u>: ____

   ____

   ____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL." (Circle response)

   YES NO

5. Please write the telephone number where you want to receive calls about your appointments, lab results, or other health care information if other than your home phone number*:

   ____

   **I am fully aware that a cellular phone is not a secure and private line.*

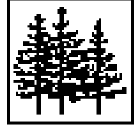
6. Can confidential messages be left on your telephone answering machine? (Circle response)

   YES NO

7. I am fully aware that my health information can be transmitted by electronic transmission, by fax transmittal, by Internet, or by e-mail.

PATIENT
SIGNATURE: ______________________________ DATE:__________________
(Guardian if under age 18 years)

-DOCTOR-
DARNELL L. MARTIN-WIMMER, M.D., F.A.A.D.
DERMATOLOGY SPECIALIST
Alpine Dermatology Associates, P.L.L.C.



WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Dr. Darnell Martin-Wimmer. I hereby acknowledge receipt of Alpine Dermatology Associates Notice of Privacy Practices.

Name [please print]: _________________________

Signature: ______________________

Date: ______________________________

OR

I am a parent or legal guardian of _______________________ [patient name]. I hereby acknowledge receipt of Alpine Dermatology Associates Notice of Privacy Practices with respect to the patient.

Name [please print]: _________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ______________________

Date: ______________________________

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED Date:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits to the undersigned physician or supplier for these services and all future claims. X	I authorize the release of any medical information necessary to process this claim and all future claims. X

PATIENT INFORMATION

Last Name: _________________________ First Name: _______________________ Middle Initial ______ Nickname: ___________

Address: ____ City, State. Zip: ____

Sex (circle one) Male Female Date of Birth: _____/_____/_____ Age: _______ Is the Patient: Single Married Widowed Separated Divorced

Phone: (______) _______ - _____________ Cell Phone (_____) ______-__________

Employer: ____ Occupation:_____________________________________

Work Address: ____ City, State, Zip: ____

Is the Patient a Student? (circle one) Yes No If YES, name of school: ____

<u>If you are married, please complete Spouse information below.</u>

Spouse's Last name: ___________________________ First name: ________________________ Nickname: ______________________

Date of Birth: _____/_____/_____ Is Spouse currently employed? (circle one) Yes No

Employer: ____ Occupation:_____________________________________

REFERRING PHYSICIAN

Who is the Patient's Referring Physician? Name: _____________________________________ Phone: __________________________

Is the Patient's Primary Care Physician the same? (circle one) Yes No

If No, PCP Name: ____ Phone: ____________________________________

NEXT OF KIN INFORMATION

Give the name of nearest relative or a close friend not living with you to contact in case of an emergency.

Name: ____ Phone: __________________ Relationship: _________________________