

Patient Information Forms

Please legibly print the following information on the front and back in black ink

**Patient Name**:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Last | | |  |  |  |  | First | |  |  | Middle | |
| **Home Address:** | | | |  | | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Street & Apt. | | |  |  |  | City | | | State | | Zip | |
| **Home Phone:** | |  | | | | |  | **Cell:** | |  |  |  |  | **Work:** |  |  |
| **Date of Birth:** | | | | | | | **Gender:** | | |  | **E-mail:** | |  |  |  |  |
|  |  | | | |  |  |  | |  | |  |  |  |  |  |  |
| **Marital Status: Single** | | | | |  |  | **Married (Spouse’s Name):** | | | | |  |  |  |  |  |

**SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Emergency Contact:**\_ | |  |  | **Relationship:** | |  |  |
|  |  | (Name) | | | | | |
| **Contact Phone:** | |  | **Alternate Phone:** \_ | | | | |
|  |  |  |  |  |  |  |  |

**I will be using insurance for my dermatology appointment:** NO YES

***If yes,***

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Insured Party: \_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Party Name: (First, Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Party DOB: \_\_\_/\_\_\_/\_\_\_

**Referral Source (check all that apply):**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | Social Media |  | Website / Web Search | |  | Magazine |  | Word of Mouth |
|  |  | TV Commercial | | |  | Yellow Pages |  | Radio |  | Other |

Patient that we can thank for referring you (Name):

**APPOINTMENT CANCELLATION/NO SHOW POLICY**

EFFECTIVE 10.1.2021

Thank you for trusting your medical and cosmetic care to Nikko Dermatology. When an appointment is scheduled with Nikko Dermatology, we set aside time to provide you with the highest quality care. Please contact our office 24-hours prior to your scheduled appointment time to cancel or reschedule. This allows staff the opportunity to contact patients who may be waiting for an appointment. Please see our *“Appointment Cancellation & No Show Policy”* below:

* A 24-hour cancellation notice is required for all medical appointments. Failure to show or cancel your appointment with **less than 24-hour notice will be charged a $50 fee.**
* A $100 deposit is required for all aesthetic treatments and procedures. Deposits will be forfeited for failing to show or cancel your appointment with **less than 24-hour notice.**

We understand there may be circumstances that require you to cancel an appointment; however, we require that you notify our office *at least 24 hours* in advance to avoid charges.

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nikko Dermatology & Cosmetic Surgery Center

Authorization for and Release of Photographs and Videos

I authorize Anthony Nikko, M.D. and his associates the right to use photographs and videos of myself for professional medical purposes deemed appropriate, including, medical purposes related to the case, before and after photographs for patients to view in the office, Nikko Dermatology and Cosmetic Surgery Center website and all outlets of social media. I understand my name will be kept private and confidential, unless I authorize.

I understand Dr. Anthony Nikko M.D. is not obligated to make use of the rights to set forth herein. I also understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

\_\_\_ I DECLINE all of my images to be posted/shared  
\_\_\_ I AUTHORIZE all my images to be posted/shared  
\_\_\_ I AUTHORIZE for my images to be posted/shared with the exception of my entire face

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(\*If patient is a minor, legal representative must sign consent\*)**

**Please check “Yes” or “No” for the following questions:**

Are you **ALLERGIC** to any medications? (List below)

NO

YES

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever been diagnosed with **Hepatitis**? |  | NO |  | YES |
| If so, CIRCLE which: Hepatitis A B C |  |  |  |  |
| Do you have or have you been exposed to the **HIV virus**? |  | NO |  | YES |
| Do you have a problem with **excessive sweating**? |  | NO |  | YES |

**Please list the cosmetic procedures, skin care and/or dermatology treatments you are interested in:**

**First day of last period:** **Number of Pregnancies:**

**What pharmacy would you like to add for prescriptions?**

**Pharmacy Name:**

**Pharmacy Address:**

**Phone Number:**

*I have received this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.*

*I fully understand that I am financially responsible for ALL medical services provided to me at the time of service.*

**Patient Signature** **Date**

(\*If Patient is a minor, legal representative must sign consent)

HIPPA Privacy Rule

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and

disclosures of their protected health information. The individual is also provided the right to request that communications be made in a confidential manner.

**I wish to be contacted in the following manner (check all that applies):**

* \* HOME Telephone Number:
  + O.K. to leave message with detailed information (e.g., appointment reminders)
  + Leave message with call-back number ONLY
* \* CELLULAR Telephone Number:
  + O.K. to leave voice/text message with detailed information (e.g., appointment reminders)
  + Leave voice/text message with call-back number ONLY
* \* WORK Telephone Number:
  + O.K. to leave message with detailed information (e.g., appointment reminders)
  + Leave message with call-back number ONLY

\*(Please check at least one) at the above number(s), you authorize our office to speak with:

* Emergency contact listed
* Patient only
* Patient and/or other authorized person(s) Please list name(s) below:

**Patient Signature** **Date**

(\*If Patient is a minor, legal representative must sign consent)



|  |  |  |  |
| --- | --- | --- | --- |
| **NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **DATE:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_** |  |
| **DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_** | **HEIGHT**: \_\_\_\_\_\_\_\_\_ **WEIGHT**:\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |
| **PAST MEDICAL HISTORY** (Please **circle** all that apply) | | Leukemia or Lymphoma |  |
| Anxiety | End Stage Renal Disease |  |
| Depression | Hearing Loss | Radiation Treatment |  |
| Arthritis | Heart Attack/Stroke | Pacemaker |  |
| Artificial Joints | Hepatitis B or C | Cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Diabetes | HIV/AIDS | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| None of the Above |  |  |  |
| **PAST SKIN DISEASE HISTORY** (Please **circle** all that apply) | | Poison Ivy |  |
| Acne | Dry Skin |  |
| Actinic Keratoses | Melanoma | Vitiligo |  |
| Pancreatic Mole | Asthma | Hayfever/Allergies |  |
| Eczema | Flaking or Itchy Scalp | Psoriasis |  |
| Basal Cell Carcinoma | Squamous Cell Carcinoma | Melanoma |  |
| None of the Above | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |

**PAST SURGICAL HISTORY** (Please **circle** all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heart Valve Replacement | Skin Biopsy |  |  | Melanoma Surgery |  |
| Squamous Cell Carcinoma Surgery | Basal Cell Carcinoma Surgery | | | Lumpectomy |  |
| Masectomy | Joint Replacement \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Cosmetic surgery |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | None of the above | |  |  |  |
| Do you wear Sunscreen? Yes No | how often? | daily | sometime | only at the beach |  |
| If Yes, what SPF?\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**FAMILY HISTORY** (Please circle all that apply)

* Do you have an immediate family history of melanoma? **Yes** or **No**. If yes (Mother Father Sister Brother or Child)
* Are there any pertinent or major skin problems that run in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **SOCIAL HISTORY:** | |  |  |
| □ Currently Smokes? Yes or No, if yes- how many\_\_\_\_ Cigarette a day, for how many year? | |  | \_\_\_\_ |
| □ | Alcohol? Yes or No, if yes, how many drinks daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| □ | Are you on any kind of diet? Yes or No**,** If yes what diet? | \_\_ | |

* What is your current and/or former occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What type of outdoor activities, if any, do you participate in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have any other hobbies or activities you would like us to know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have any children or pets? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* With whom, if anyone, do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Where do you live (generally speaking: what town or city or county, assisted living facility)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* Are you currently using any dermatology lotion for skin care? Yes or No, if yes what product?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are you interested in cosmetic surgery? Yes or No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS (**Please List any medications, including vitamins and supplements, doses & frequencies, tablet or liquid)

|  |  |  |
| --- | --- | --- |
| **Medications** | **Doses** | **Directions** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES TOP MEDICATIONS (**Please list any medication allergies and the **type of reaction** that occurred**)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REFERRING DOCTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DERMATOLOGY ALERTS** (Please **circle** any of these important alerts if they apply to you)

Allergy to topical antibiotic

Rapid heartbeat with epinephrine

Allergy to adhesive

Allergy to Lidocaine

Artificial heart valve Defrillator

Artificial joints within last 2 years Pacemaker

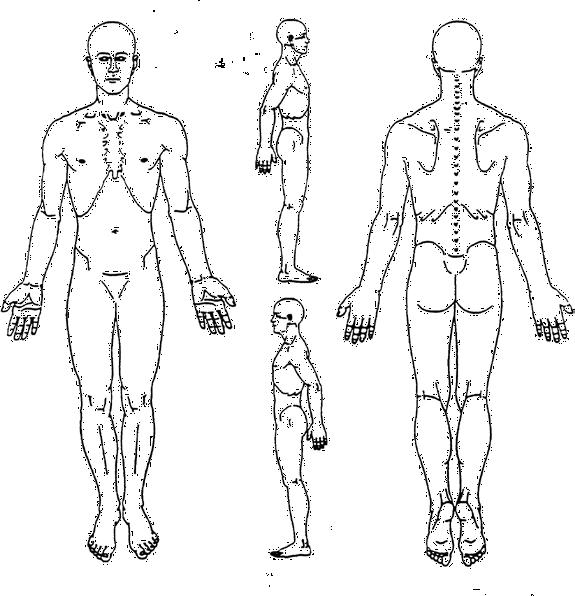
Premedication prior to procedures Pregnant, planning or nursing

Blood thinners Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE DETAIL THE REASON FOR TODAY’S VISIT**

**Location: (Mark Site on chart below)**

**Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Quality:** Symptomatic Itch bleed tender scaly

rough darker enlarging

**Severity:** **mild** **moderate** **severe**

**Duration:** How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Treatments:**

(Lotions, OTC, Prescription orother?)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes it better or worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any other rashes?** YES or NO

**Do you have any problems with allergy or your immune system?** YES or NO

**Do you have any stress?** YES or NO, If yes, how significant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have problems with scarring?** YES or NO

**Do you have problems with bleeding?** YES or NO

*Would you like to speak to our Aesthetician* *about a skin care regimen or product advice?* \_\_\_\_NO \_\_\_\_YES



*\*\*for patients using insurance*

**Assignment of Benefits Form**

I hereby irrevocably assign and/or convey directly to Nikko Dermatology and/or its contracted healthcare providers as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Nikko Dermatology for today’s treatment/services and future treatment/services, regardless of its managed care network participation status. This Assignment of Benefits shall apply to all insurance coverage, including but not limited to the Centers for Medicare and Medicaid Services, its intermediaries, carriers or administrative contractors, State Medicaid programs, or any other governmental or commercial insurance. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Nikko Dermatology to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy(ies), and/or settlement information upon written request from Nikko Dermatology or its attorneys in order to claim such medical benefits. I authorize Nikko Dermatology to appeal any and all claim denials or rejections on my behalf.

I intend by this assignment and designation of authorized representative to convey to Nikko Dermatology all of my rights to claim the medical benefits related to the services, treatments, therapies, and/or mediations provided by Nikko Dermatology, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Nikko Dermatology) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Nikko Dermatology as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

I understand that if Nikko Dermatology is not paid in full by proceeds from any insurance policies then I may be responsible for all or part of the remaining balance due.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_