DERMATOLOGY CENTER of MCKINNEY

PAYMENT POLICY

PAYMENT POLICY:

Basic Policy—Pay for service is due in full at the time service is provided in our office. A government issued photo I.D. is required to be seen. Minors must be accompanied by a parent, legal guardian, or have a signed document granting approval.

HMO, PPO or other managed care patients—You will be responsible for paying your annual deductible, copayment charges, balances and any non-covered or cosmetic services at the time of service. We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Commercial Patients—Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.
Medicare Patients—We will bill Medicare for you. We will also bill secondary insurance carriers for you.
All copayments or deductibles are due and payable at the time service is provided.
Medicare Patients: Signature on File—For the convenience of our Medicare patients and to expedite billing of services to Medicare on their behalf, Dermatology Center of McKinney will request and maintain your signature on file.
Medicaid—At this time, we do not accept Medicaid.
Surgery Fees—All copays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.
Non-covered Services—Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
Personal Injury Cases—This office does not bill for auto accident or other liability or lawsuit-related cases.
You are responsible for payment at the time of service. We do not accept liens.
Worker's Compensation—If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

Yearly Skin Screenings—Periodic preventive skin screenings may or may not be covered under your health insurance policy; however, they may be required by your physician.

NO-SHOW POLICY:
If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time. Our no-show policy is as follows: a 24-hour notice is required. After the first no-show appointment you will receive a phone call to remind you of the missed appointment and to reschedule your appointment. After the second no-show you (not your insurance company) will be charged $50 ($100 for surgeries) for the time slot we were not able to fill when you were a no-show. You will be required to hold subsequent appointments with your credit card information. On the third no-show, it will be the physician's discretion as to whether a discharge letter will be sent out disengaging you from the practice and giving you 30 days to enroll with a new physician.

Assignment of Insurance Benefits—For the convenience of our insured patients and to expedite billing of services to their insurer on their behalf, Dermatology Center of McKinney will request that you complete and sign the Assignment of Insurance Benefits form provided.

The patient is ultimately responsible for all professional fees.

JAMES RALSTON, MD
4510 MEDICAL CENTER DRIVE · SUITE 303 · MCKINNEY, TEXAS 75069 · 972-548-0333 · 972-548-0348 FAX · WWW.DERMATOLOGYMCKINNEY.COM

Patient Portal

This practice offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

ePrescribing

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions: Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions: Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

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DERMATOLOGY CENTER of MCKINNEY

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. ***Treatment, Payment, Health Care Operations***

Treatment—We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment—We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations—We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. We may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care. We may use your medical information to conduct cost-management and business planning activities for our practice. We may disclose your medical information to other health care providers and entities to assist in their health care operations.

ePrescribing—is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

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- Fill status notification: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

B. ***Disclosures That Can Be Made Without Your Authorization***

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight.

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information when the disclosure is required by law.

C. ***Your Rights Under Federal Law***

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. ***Appointment Reminders, Treatment Alternatives, and Other Benefits***

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. ***Our Promise to You***

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. ***Questions and Contact Person for Requests***

If you have any questions or want to make a request pursuant to the rights described above, please contact:

James P. Ralston, M.D.
4510 Medical Center Dr., Suite 303
McKinney, Texas 75069
(972) 548-0333 (phone)
(972) 548-0348 (fax)
This notice is effective 11/01/2008.

DERMATOLOGY CENTER of MCKINNEY

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES:

My signature below indicates that I have received and reviewed a copy of my physician's **Notice of Uses**, Disclosures of Protected Medical Information (**Notice of Privacy Practices**), and **Payment Policy**. I have been given the option of signing a separate Patient Consent Form.
Patient or Responsible Party Signature _____ Date ____/____/____

PATIENT CONSENT FORM

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees
- I authorize the Dermatology Center of McKinney and Dr. James Ralston to take medical photographs of myself or my child (or person for whom I am a legal guardian). I understand that the information will be used to enhance my medical record.
- **RX history consent**: By signing this consent form I am agreeing that the Dermatology Center of McKinney and Dr. James Ralston can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Dermatology Center of McKinney and Dr. James Ralston to enroll me in the ePrescribe Program as described in the Notice of Privacy Practices.

- I fully understand that this is given in advance of any specific diagnosis or treatment.
- I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
- I understand that **Dermatology Center of McKinney/James P. Ralston, M.D.**, may include consent at satellite offices under common ownership.
- I, the undersigned, authorize **Dermatology Center of McKinney/James P. Ralston, M.D.**, to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.
- A photocopy of this consent shall be considered as valid as the original.

Patient Portal Consent: I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Dermatology Center of McKinney/James P. Ralston, M.D.**

I acknowledge that I have been given the **Dermatology Center of McKinney/James P. Ralston, M.D.,** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact **James P. Ralston, M.D**. Patient Initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Patient Signature (or Responsible Party) **Date**

JAMES RALSTON, MD
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PATIENT INFORMATION

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change			Today's Date:
PATIENT INFORMATION			
Patient's Last Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. First: Middle:		Date of Birth	Sex (Male / Female):
Address:	City:	State:	ZIP Code:
Race: ☐ American Indian, ☐ Asian, ☐ Native Hawaiian, ☐ Black/African American, ☐ White, ☐ Hispanic, ☐ Other			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Language: ☐ English ☐ Spanish ☐ Indian ☐ Other		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed «MaritalStatus»			
Home #.: ( )	Work #.: ( )	Cell #.: ( )	
PARENT, SPOUSE, or RESPONSIBLE PARTY *(if different from patient)*			
Last Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. First: Middle:		Date of Birth	Sex: ☐ Male ☐ Female
Address:	City:	State:	ZIP Code:
Home #.: ( )	Work #.: ( )	Cell #.: ( )	
INSURANCE COVERAGE—PRIMARY			
Insurance Company Name:		Policy Type: ☐ HMO ☐ PPO ☐ HSA ☐ Other _____	
Policy #:		Group Name or #:	
Address of Claim Center:	City:	State:	ZIP Code:
Customer Service #: ( )	Providers # (if different): ( )	Fax #: ( )	
Name of Policy Holder (Insured):		Policy Holder (Insured) Date of Birth:	
Relationship to Insured: ☐ Mother ☐ Father ☐ Other _____			
Please check one: I have paid my insurance deductible for the calendar year _____ ☐ YES ☐ NO ☐ Don't know			
INSURANCE COVERAGE—SECONDARY			
Insurance Company Name:		Policy Type: ☐ HMO ☐ PPO ☐ HSA ☐ Other _____	
Policy #:		Group Name or #:	
Address of Claim Center:	City:	State:	ZIP Code:
Customer Service #: ( )	Providers # (if different): ( )	Fax #: ( )	
Name of Policy Holder (Insured):		Policy Holder (Insured) Date of Birth:	
Relationship to Insured: ☐ Mother ☐ Father ☐ Other _____			

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PATIENT MEDICAL HISTORY

Patient's Last name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.	First:	Middle:	Date of Birth	Today's Date	SS#:

Primary Care Physician or Pediatrician:

How did you hear about us?

EMERGENCY CONTACT INFORMATION

Emergency Contact's Name (First, Last):		Relationship to Patient:
Home #.: ( )	Work #.: ( )	Cell #.: ( )

Do you give our office permission to discuss your medical information with family members?
☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

May we leave personal medical information on your answering machine or cell phone? ☐ YES ☐ NO

May we e-mail personal medical information to you (This will register you on our secure patient portal)? ☐ YES ☐ NO

E-mail address: _____

Would you like to receive our free newsletter by email? ☐ YES ☐ NO (Please note, your email address will ONLY be used for the purpose of receiving our newsletter and will not be sold or made available for use by any other organization. You always have the option of unsubscribing from the mailing list with every newsletter you receive.)

MEDICAL QUESTIONAIRE

In order to help you physician better assess your medical problem and make appropriate treatment recommendations, we ask that you fill out this medical questionnaire. This is an important part of your medical evaluation and your physician will use this form as a guide for a more detailed medical history.

GENERAL

Briefly state what symptoms you are experiencing which prompted you making an appointment, and indicate how long you have had these symptoms

Symptom:	Duration:

Have you had this skin problem before: ☐Yes ☐No	What makes it better:	What makes it worse:

Are you being treated/followed for any other medical problems?:

MEDICAL HISTORY

Do you have a specific skin disease? ☐Yes ☐No:

Drug Allergies:	Food Allergies:

Other Allergies:

Have you had skin cancer before? ☐Yes ☐No:	If yes, type?:	If yes, when?:

Women: Are you pregnant? ☐Yes ☐No	Are you nursing? ☐Yes ☐No
Is your menstrual cycle regular? ☐Yes ☐No	Date of last menstrual period:

Present Medications (include over-the-counter & herbal supplements/vitamins)

Name	Dose	How Often
1.		
2.		
3.		

Preferred Pharmacy Name:	**Pharmacy location (city and address or cross street):**

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SURGICAL PROCEDURES

Type of Operation:	Year:

Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No		Yes	No
Bronchitis	☐	☐	HIV (AIDS)	☐	☐	Frequent Bladder Infections	☐	☐
Emphysema	☐	☐	Hepatitis	☐	☐	Yeast infections on antibiotics	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Fainting	☐	☐
Chronic Cough	☐	☐	Excessive thirst/hunger	☐	☐	Convulsions or Seizures	☐	☐
Shortness of Breath	☐	☐	Thyroid Problems	☐	☐	Arthritis/Joint Deformity	☐	☐
Wheezing	☐	☐	Kidney Problems	☐	☐	Limited Joint Motion	☐	☐
Heart Attack	☐	☐	Stomach Absorption Disorder	☐	☐	Artificial Joint		
Stroke	☐	☐	Nausea, Vomiting, Diarrhea					
Pacemaker/Defibrillator	☐	☐	when taking antibiotics	☐	☐	Blood Clots	☐	☐
High blood pressure	☐	☐	Chest Pain	☐	☐	Inflammation of Veins	☐	☐
Heart Murmur	☐	☐	Irregular Heartbeat	☐	☐			

Any other diseases or conditions:_____

FAMILY HISTORY

What kind of skin problems run in your family:

Allergy History: ☐Yes ☐No	Dry Skin: ☐Yes ☐No	Eczema: ☐Yes ☐No
Skin Cancer: ☐Yes ☐No	Types:	Hair/Nail Problems: ☐Yes ☐No

Other Health Problems:

SOCIAL HISTORY

Occupation:	Hobbies:	Recent Travel: ☐Yes ☐No Where?:
Pets:	Children:	Family members with similar condition? ☐Yes ☐No
Smoke: ☐Yes ☐No How much?	Drink Alcohol: ☐Yes ☐No How much?	Do you wear sunscreen daily? ☐Yes ☐No

REVIEW OF SYSTEMS

Have you developed any other problems with other body systems associated with your skin problems (specify problem)?

Headaches	Lungs	Bone
Eyes	Heart	Muscle
Ears	Bladder	Weakness
Nose	Urination	Tremors
Throat	Genitals	Bleeding/Easy Bruising
Bowels	Psychiatric	Dizziness

Patient Signature:_____ Today's Date: _____

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