BURKE DERMATOLOGY

Patient Name: _____ D.O.B: _____
Address: _____ City:_____ State: ____
Email: _____

PAST MEDICAL HISTORY:
Personal history of cancer other than skin_____

__Anxiety	__COPD	__High Blood Pressure	__Thyroid Issues
__Arthritis	__ Depression	__Inflammatory Bowel Disease	__Radiation Treatment
__Asthma	__ Diabetes	__Organ Transplant, Type:_____	__Stroke
__Eczema	__Psoriasis	__Hay Fever	__Heart Disease

Other Medical History not listed:_____

HISTORY OF SKIN DISEASE:
Personal History of Skin Cancer? __Basal Cell Carcinoma __Squamous Cell Carcinoma __Melanoma
DO YOU HAVE A FAMILY HISTORY OF MELANOMA? Relative(s):_____

MEDICATION: Check here if you have an attached list _____
Please include dosage and strength if known _____
_____
_____

Patient Height: _____ Patient Weight: _____ (Required for prescriptions)

ALLERGIES:_____
_____

SOCIAL HISTORY: Do you smoke? __Yes __No Do you drink alcohol? __Yes __No

ALERTS:

__Allergy to Adhesive	__On Blood Thinners/Aspirin	__MRSA
__Allergy to Lidocaine	__History of Fever Blisters	__Seizures
__Allergy to Latex	__Pacemaker	__Kidney disease
__Allergy to Iodine	__Defibrillator	__C-Diff
__Artificial Joint	__HIV/AIDS	__Pregnant or trying to get pregnant
__Artificial Heart Valve	__Hepatitis B	__Breast Feeding
__Allergy to Oral Antibiotics	__Hepatitis C	__Neurostimulator/implantable device
__Requires Antibiotics prior to procedure		

Pharmacy Name:_____ Pharmacy Address: _____
Primary Care Physician:_____

Do you authorize our clinic to discuss your medical information with family members, including biopsy results, lab results, office notes and other test results? Yes/No Who _____

Do you authorize our clinic to leave a detailed voicemail, text, and/or email? Yes/No

SIGNATURE:_____ DATE:_____

BURKE DERMATOLOGY

INFORMED CONSENT FORM: GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY

Dr. Burke may recommend you undergo medical treatment, administration of local anesthesia and the performance of procedures and/or minor surgery. Please read this document carefully. Before signing this document, please ask your physician about any aspect of this document, or the procedure, that you do not understand. This will serve as a standing consent for any and all future treatments, however verbal consent will always be obtained prior to any treatment.

* I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional or intramuscular cortisone (a steroid), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by Dr Burke or an appropriately trained heath care personnel on the staff of the Burke Dermatology, for or upon me, an individual to which I am designated the guardian or guarantor, or my minor dependent child.

* I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of Burke Dermatology or it's designates herein, of any tissue or parts which may be removed.

* I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or in discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.

* I understand that all specimens removed are sent for dermatopathologic analysis and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of the charges.

* I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses may be deemed necessary by Dr Burke, to prevent the risk that these lesions evolve into Squamous Cell Carcinomas.

* I understand that the destruction by liquid nitrogen of warts or mollusca may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they may be recommended to be treated. Should Dr Burke, recommend destruction of these lesions by liquid nitrogen, cantharidin, 5-fluorouracil or other destructive method, I consent based on that advice. I am aware that these lesions may require more than a single treatment.

* I understand that the injection of cortisone for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable, or desirable by Dr Burke.

* I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

* I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD AND RECEIVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLANATIONS REGARDING THE PROVIDED INFORMATION.

Patient*: _____ Date: _____

BURKE DERMATOLOGY

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Burke Dermatology reserves the right to change the privacy policy as allowed by law.
- Burke Dermatology has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Assignment of Benefits
Please understand that whatever health insurance you carry, the insurance is not responsible to the physician for your bill. You are responsible to the physician. Please check to make sure we are in your insurance network. All HMO insurances require a referral to see a specialist. I authorize Burke Dermatology SC, and their billing company, to submit to my insurance company for services rendered and agree to assume financial responsibility for all charges NOT covered by my insurance company. I also authorize the release of any medical information necessary to process these claims.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and/or other health plans to Burke Dermatology. This assignment will remain in effect until revoked by myself in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance.

I agree to pay the reasonable attorney fees and cost incurred in collection of past due amount plus interest at a legal rate for money judgments.

Consent Photo
I consent to the taking of photographs of my skin lesion(s). I understand that these photographs will be a part of my medical record.

Consent to call or L/M lab results
I give my permission for a representative of Burke Dermatology to leave messages regarding test results on my answering machine (cell and home) and/or communicate or leave messages with my emergency contact.

Consent to text
I give my permission to be contacted by SMS text and understand the risks of communication personal information over an unencrypted channel.

_____ _____

Signature Date