Melissa Morgan, M.D., P.C
Dermatology Medical History

Patient: _____ Date of Birth: _____Today's Date: _____
Reason for today's visit:_____

Are you allergic to any medications? □ **YES** □ **NO** If yes, please list: _____

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1._____ 3._____ 5._____

2._____ 4._____ 6._____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs	**YES**	**NO**
Emphysema	____	____
Asthma	____	____
Tuberculosis	____	____
Blood Clot	____	____
(Pulmonary Embolus)	____	____
Cardiovascular	____	____
High Blood Pressure	____	____
Chest Pain	____	____
Heart Attack	____	____
Heart Murmur	____	____
Irregular heartbeat	____	____
Phlebitis	____	____
Inflammation of vein	____	____
Blood clots	____	____
Pacemaker	____	____
Automatic Internal Defibrillator	____	____
Cancer	____	____
Type: _____		
Year:_____		

Other Systemic	**YES**	**NO**
Diabetes	____	____
Lupus	____	____
Thyroid	____	____
Kidney	____	____
Dialysis	____	____
Depression	____	____
Gastrointestinal	____	____
Crohn's Disease	____	____
Inflammatory Bowel Disease	____	____
Hepatitis	____	____
Stomach ulcers		
Yeast infection when taking antibiotics	____	____
Arthritis	____	____
Fever blisters on lips	____	____
Joint Replacement		
Type: _____ Year:_____		
Convulsions, Epilepsy	____	____
Seizures	____	____
Fainting	____	____
Glaucoma	____	____

List any other diseases or conditions:_____
List any surgical procedures you have had in the last 6 months_____

Skin:

Have you ever had skin cancer? □ **YES** □ **NO**
Has anyone in your family had skin cancer? □ **YES** □ **NO**
Do you have a history of any specific skin diseases? □ **YES** □ **NO** If yes, _____
Do you have problems with healing? □ **YES** □ **NO**
Do you develop keloids (scars) after surgery? □ **YES** □ **NO**
Do you bleed easily? □ **YES** □ **NO**
Do you develop skin rashes in reaction to: □ Medications □ Food □ Environment □ Bandages □ Topical Neosporin
□ Other: _____

Social History:

Have you ever used a tanning bed? □ **YES** □ **NO** If yes, how many times? _____
Do you drink alcohol? □ **YES** □ **NO** If yes, _____drinks per day
Do you use IV drugs? □ **YES** □ **NO** If yes, what?_____How often?_____
Do you smoke? □ **YES** □ **NO** If yes, how much?_____
Have you had or have you been exposed to HIV(AIDS)? □ **YES** □ **NO**
Please answer the following questions:
Are you pregnant? □ **YES** □ **NO** Due Date: _____
Are you nursing? □ **YES** □ **NO**
What is your occupation? _____Hobbies?_____

_____ ____/____/_____
Signature of Patient Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

CONSENT FOR ROUTINE MEDICAL TREATMENT

Melissa Morgan M.D., P.C., and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by Melissa Morgan M.D., P.C., and are accessible to its personnel and medical staff for use in my care. Melissa Morgan M.D., P.C., personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Melissa Morgan, M.D., P.C., is authorized to disclose all or part of my medical record to any insurance carrier, pharmacy, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Melissa Morgan M.D., P.C.,'s charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the **information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to Melissa Morgan, M.D., P.C., except to the extent we have already acted in reliance on it.**

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for Melissa Morgan M.D., P.C., charges payable to the insured are to be made payable to Melissa Morgan, M.D., P.C., and that insurance benefits for services provided by physicians in the practice setting otherwise payable to the insured are to be made payable to the physicians(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

You understand that Melissa Morgan, M.D., P.C., will assist with insurance precertification requirements which are the responsibility of the policyholder and/or practice, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by Melissa Morgan, M.D. P.C., Charges for services and goods shall be at Melissa Morgan M.D., P.C.,'s billed charges rates unless otherwise agreed to in writing by Melissa Morgan, M.D., P.C. **Failure to cancel your appointment within 24 hours, may result in a $50.00 fee. The fee for cosmetic or surgical appointment cancellations is $85.00_____(initials).**

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____

Signature of Patient or Patient's Legally Authorized Representative **(Documentation Must Be Provided)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Melissa M. Morgan, M.D, P.C., is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment.
The Notice is posted throughout our office and you will be given a copy for your personal use upon request.

I have received a copy for review of Melissa Morgan, M.D., P.C.'s Notice of Privacy Practices dated: April 14, 2003

_____	_____	_____
Patient or Representative	Legal Authority of Representative	Date signed

Basis of refusal, if refused: _____

Authorization to disclose Pathology or lab results to: _____
Name Relationship

PATIENT INFORMATION Today's Date _____

Name_____ **SS#**_____
Last *First* *M.I.* ***Social Security Number***

Home Address_____
Street *City* *State* *Zip*

Home Phone_____ Work Phone _____Cell Phone_____

Date of Birth ____/____/_____ Age_____ Sex _____ Marital Status _____ Drivers License # _____

Email Address_____ Visitor with Patient_____

PARENT OR GUARDIAN *(If different from patient)* Relationship_____Phone Number_____

Name _____
Last *First* *M.I.*

Address_____
Street *City* *State* *Zip*

Home Phone_____ Work Phone _____ Cell Phone _____

Date of Birth ____/____/_____ Sex _____

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

Primary Insurance Name_____
Name of Insured_____
Insured's Date of Birth_____
Insured's ID# _____
Group # _____
Employer Name_____
Relationship of patient to the Insured _____

Secondary Insurance Name_____
Name of Insured_____
Insured's Date of Birth_____
Insured's ID# _____
Group # _____
Employer Name_____
Relationship of patient to the Insured _____

Other family members that are patients_____
Pharmacy of choice_____ Phone # _____
In case of Emergency, who should be notified? _____
Primary Care Physician _____

I authorize the release of medical information to my primary care orreferring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date _____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. **APPLICABLE CO-PAYMENTS AND DEDUCTIBLES WILL BE COLLECTED.** We accept payment in the form of cash, check, or credit card (VISA or MasterCard). If we are filing insurance, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Insufficient check charges are $25.00. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date _____/_____/_____