MRN

Name

DOB

Patient stamp or label above

UNIVERSITY CLINICAL HEALTH
Dermatology

930 Madison Avenue, Suite 801
Memphis, Tennessee 38103 – 3410
P 901.866.8790 | F 901.302.2790

New Patient Questionnaire

What is the best contact phone number for you? _____

Primary Care Physician: _____ Referred by: _____

Reason for your visit today? _____

Current Medications (use back if needed): _____

_____

Pharmacy Name and Phone Number: _____

Drug Allergy / Other Allergies (including latex, tape, sutures, etc.): _____

_____

Are you experiencing any of the following? (Check all that apply)

- ❒ Chills
- ❒ Fatigue
- ❒ Fever
- ❒ Night sweats
- ❒ Weakness
- ❒ Weight gain
- ❒ Weight loss
- ❒ Dry skin
- ❒ Itching
- ❒ Nail changes
- ❒ Mouth sores
- ❒ Light sensitivity
- ❒ Anxiety
- ❒ Headache
- ❒ Depressed mood
- ❒ Suicidal thoughts
- ❒ Blurred vision
- ❒ Burning eyes
- ❒ Decreased night vision
- ❒ Dry eyes
- ❒ Sinus pain
- ❒ Tearing
- ❒ Vision changes
- ❒ Cough
- ❒ Wheezing
- ❒ Chest pain
- ❒ Swelling
- ❒ Palpitations
- ❒ Varicose Veins
- ❒ Abdominal pain
- ❒ Constipation
- ❒ Diarrhea
- ❒ Heart burn
- ❒ Nausea
- ❒ Vomiting
- ❒ Dark urine
- ❒ Irregular menstrual cycle
- ❒ Cold intolerance
- ❒ Heat intolerance
- ❒ Arthritis
- ❒ Muscle spasms
- ❒ Muscle weakness
- ❒ Blood clots
- ❒ Easy bleeding
- ❒ Easy bruising
- ❒ Enlarged lymph nodes
- ❒ Food allergies
- ❒ Environmental allergies

(Female patients only)
Are currently, or any chance you could be pregnant? _____

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Ht: _____ in. Wt: _____ lbs. Temp: _____ °F BP: _____ /_____ HR: _____ bpm R: _____ bpm

New Patient: ❒ Yes ❒ No ❒ M ❒ F ❒ Full Exam ❒ Focused Exam ❒ Gown

> 18 yo ❒ Yes ❒ No Parent / guardian present or consent ❒ Yes ❒ No

Resident physician consent ❒ Yes ❒ No

Past Medical History: (Check all that apply)

- ❒ Allergies: _____
- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Atrial fibrillation
- ❒ Blood clots
- ❒ Cancer: _____
- ❒ Cardiovascular disease
- ❒ Congestive heart failure
- ❒ COPD
- ❒ Coronary artery disease
- ❒ Depression
- ❒ Diabetes
- ❒ Eczema
- ❒ Elevated lipids
- ❒ Gastrointestinal disease
- ❒ Glaucoma
- ❒ Hepatitis / liver disease
- ❒ Hypertension
- ❒ Mental disorder
- ❒ Multiple Sclerosis
- ❒ Osteoporosis
- ❒ Phlebitis
- ❒ Renal disease
- ❒ Seizure disorder
- ❒ Skin cancer
- ❒ Thyroid disease
- ❒ Tuberculosis
- ❒ HIV
- ❒ Other: _____

Past Surgical History: (Check all that apply)

- ❒ Blood transfusion
- ❒ CABG
- ❒ Cardiac pacemaker
- ❒ Hip replacement
- ❒ Hysterectomy
- ❒ Knee replacement
- ❒ Liver biopsy
- ❒ Organ transplant
- ❒ Electronic implanted bone / brain stimulators
- ❒ Other: _____

Social History:

Do you use tobacco? ❒ Yes ❒ No If so, what type? _____ How much often? _____

Do you use alcohol? ❒ Yes ❒ No If so, what type? _____ How much often? _____

Marital status: _____ Occupation: _____

Pediatric patients only:

With whom does patient live? _____

Who has quardianship of patient? _____

Does anyone in the home smoke? ❒ Yes ❒ No

Family History: (Check all that apply to blood relationships only)

- ❒ Abnormal moles
- ❒ Acne
- ❒ Allergies
- ❒ Arthritis
- ❒ Asthma
- ❒ Basal cell carcinoma
- ❒ Blood disorder
- ❒ Cancer: _____
- ❒ COPD
- ❒ Coronary artery disease
- ❒ Depression
- ❒ Dermatitis
- ❒ Diabetes
- ❒ Eczema
- ❒ Elevated lipids
- ❒ Genetic disease
- ❒ Hypertension
- ❒ Inflammatory bowel disease
- ❒ Keloids
- ❒ Liver disease
- ❒ Psoriasis
- ❒ Renal disease
- ❒ Rosacea
- ❒ Seizure disorder
- ❒ Stroke
- ❒ Thyroid disorder
- ❒ Melanoma
- ❒ Other: _____

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UNIVERSITY CLINICAL HEALTH

Consent and Agreement

Part I. Medical Treatment Consent:

I (the undersigned, and/or the parent or legal guardian) consent to the administration of reasonable and necessary services in connection with treatment of the above-mentioned patient at University Clinical Health (UCH). This consent includes, but is not limited to, laboratory procedures, medication administration, infusions, procedures, and/or services rendered to a patient by members of the medical staff, their representatives, and/or associates, and employees under the instruction of the physician. I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the clinic.

Part II. Release of Information, Assignment of Insurance Benefits, and Financial Agreement:

Release of Information: I hereby authorize UCH and any physician who has rendered services to release any and all information pertaining to my (or the patient's) treatment to enable the collection of benefits for the services rendered. The authorization includes release of information to insurance companies or healthcare providers, in whole or in part, for payment in exchange for services rendered, whether such payment is in exchange for services rendered by UCH or by the physicians. Release of Information is also authorized to any providers for follow-up medical care. A copy of UCH's *Request for Restrictions Form* must be submitted in writing to terminate this agreement.

Assignment of Benefits: I hereby authorize and assign payment directly to UCH for benefits, including secondary benefits, due to me for medical services. I understand that I am financially responsible for charges not covered by any insurance or medical benefit payor. I further acknowledge that any benefits, when received by and paid to UCH will be credited to my account in accordance with this assignment.

Financial Agreement: I understand and agree that I am financially responsible to UCH, and/or physician for any charges not covered by the authorization below or charges not covered by insurance.

I agree that in order to collect any amounts I may owe for services provided by UCH, UCH or its designee may contact me via telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in cellular charges. We may also contact you by sending text messages or e-mails, using any e-mail address you provided to us. Methods to contact may include using pre-recorded/artificial voice messages and or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that UCH and/or its designee for collecting any amounts I may owe UCH may contact me as described above.

In addition, with respect to future treatments at UCH, this document is ongoing in nature and will remain in effect until revoked by me in writing.

I hereby give permission to receive services and treatment by my physician (and/or associates) at UCH I authorize the release of information including protected health information as needed to file for payment for services incurred. I fully understand my Financial Responsibility for services rendered at UCH.

Signature of Patient or Personal Representative*	Printed Name of Patient or Personal Representative*
Date	*Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one): ❑ Minor ❑ Incompetent

❑ Other (explain): _____

For Office Use Only: **Date received** _____ **Received by:** _____

Check if applicable: ❑ Patient refused to sign Consent and Agreement (explain): _____

UNIVERSITY CLINICAL HEALTH

Health Information Management - Medical Records
1407 Union Avenue, Suite 700
Memphis, Tennessee 38104-3600
901-866-8400 • Fax: 901-302-2400

Summary of Notice of Privacy Practices

Dear Patient,

Thank you for choosing University Clinical Health (UCH). Each time you visit one of our health care providers, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. The doctors and staff of UCH use and maintain this and other health information related to the care you receive from us.

The attached version of our full Notice of Privacy Practices contains information to help you understand what is in your medical record and how your health information is used. This lets you better understand who, what, when, where, and why others may have access to your health information. It also helps you ensure the correctness of such information.

Please keep the full Notice and take it home with you. **You may read it now or later**. In either case, let us know if you have any questions after reviewing it. If you did not receive the full Notice, please ask the front desk staff person for a copy.

Please sign below to show that you received UCH's full Notice:

_____ _____

Signature of Patient or Personal Representative* Printed Name of Patient or Personal Representative*

_____ _____

Date *Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one):

❑ Minor ❑ Incompetent ❑ Other (explain): _____

For Office Use Only

Date received: _____ Patient MRN: _____

Received by (employee name): _____

❑ (Check if applicable) Patient refused to sign acknowledging receipt of the full Notice (explain):

_____

_____