Shah DERMATOLOGY

Center for Advanced Aesthetics

Annual Information Update

**If any changes to your information or insurance, let us know. Thank you.*

Patient's Name _____ DOB (MM/DD/YYYY) _____

Occupation _____ Primary Doctor Name _____

Name of Insurance _____ Pharmacy _____

Responsible Party/Guarantor (if other than patient) **Please provide a copy of insurance card.*

Guarantor Name _____ DOB _____ Relation to Patient _____

Mailing Address (inc. Apt. #) _____ City _____ State _____ Zip _____

Home Phone ☐ Primary # _____ Mobile Phone ☐ Primary # _____ Work Phone ☐ Primary # _____

Email _____

Detailed Messages

Do you give our office permission to leave detailed messages at your preferred phone number regarding any tests that you may incur as a patient, including but not limited to: biopsy results, blood/lab results, or other test results? ☐ Yes ☐ No

Medications, Medical History & Allergies **Use more space as needed (or attach list).*

List all medications you are currently taking that you have not previously reported to our office (including prescriptions, over-the-counter, vitamins, herbals, and birth control pills or devices).

If no changes, please check here: ☐

Name _____ Dosege _____ Frequency _____

Name _____ Dosege _____ Frequency _____

Name _____ Dosege _____ Frequency _____

Name _____ Dosege _____ Frequency _____

Women Only

Are you pregnant, breastfeeding, or planning to become pregnant? ☐ Yes ☐ No

Since your last visit, any changes to your medical history (conditions, surgeries, hospitalizations? Describe below.

If no changes, please check here: ☐

Since your last visit, do you have any new **medication**, adhesive tape, or latex **allergies**?

If no changes, please check here: ☐

Name _____ Reaction _____

Social & Other (REQUIRED)

Have you ever smoked/used tobacco (includes vaping, hookah, and e-cigarettes)?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke/use tobacco now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No Types? _____ # times/week _____

Do you have a **Healthcare Proxy** in the event you cannot make your own decisions?

☐ Yes ☐ No

Do you have a **living will**?

☐ Yes ☐ No

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Annual Information Update

Continued

Consent to Treatment

☐ **Consent to Photography**
I authorize Shah Dermatology, LLC and its agents to use photography to enhance my medical record. My photograph or likeness will be part of the medical record and not used for any educational or promotional purposes or shared with any other third party without my written consent. The use of these photos is strictly for medical record keeping.

☐ **Consent to In-Office Procedures**
I voluntary give my consent for treatment and also my consent to any procedure that my provider performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridgement of wounds, injections of skin lesions, cauterizations of skin lesions, surgery/electro cautery. I understand that my provider will discuss in d tail any procedure he/she plans to perform, answer all questions relating to the procedure and obtain oral informed consent in the exam room.

Policies & Acknowledgements **All Office policies, Privacy Notices, and Office Collections policies can be found on our website.*

☐ I acknowledge and will comply with the information contained within the practice's **Office Policies and Office Collections Policies**. I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

☐ I acknowledge and consent to the information contained within the practice's **Notice of Privacy Practices**. I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

Signature (Patient or Legal Representative)

Date

Print Name of Signer

St. Mary's Medical Center (Charlotte Hall) 37767 Market Drive, Suite 200 | Charlotte Hall, MD 20622 **P** 301.884.0278 **F** 301.884.8663
J.P. Jarboe Medical Center (California) 22590 Shady Court, 3rd Floor | California, MD 20619 **P** 301.994.8010 **F** 301.373.9197
MedStar Shah Medical Center (Waldorf) 10 St. Patricks Drive, 3rd Floor | Waldorf, MD 20603 **P** 240.448.2970 **F** 301.638.7257

www.shahdermatologyLLC.com