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Phone #586-207-2244 / Fax #586-307-4877
www.stclairdermatology.com
German Treyger, DO FAAD

Patient Information:

Initials: _____

Full Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Address: _____

Primary Care Doctor: _____

Phone Number: _____ Address/Location: _____

I authorize St. Clair Dermatology to disclose my Protected Health Information (PHI) to the recipient(s) specified below:

Contact #1

Name: _____ Relationship: _____

Phone Number: _____ Organization/Entity: _____

Address: _____

Contact #2

Name: _____ Relationship: _____

Phone Number: _____ Organization/Entity: _____

Address: _____

This authorization is valid for one year and will be updated one year from the date signed.

I understand that:

1. Voluntary Consent: My consent to release my PHI is entirely voluntary and I have a right to decline or withdraw my consent at any time, except to the extent that action has been taken based on this consent.
2. No Effect on Treatment: Refusal to sign this form will not affect my ability to receive treatment, payment, or eligibility for benefits.
3. Re-disclosure: Once my PHI is disclosed to the recipient, it may be re-disclosed by the recipient, and my PHI may no longer be protected by federal privacy regulations.
4. Revocation: I may revoke this authorization at any time by providing a written request to St. Clair Dermatology. However, this revocation will not apply to actions taken in reliance on this authorization before its revocation.
5. Access to Information: I have the right to request a copy of this authorization at any time.

By signing below, I indicate that I have read and understood the terms of this Release of Protected Health Information form and provide my voluntary consent for the purposes outlined herein.

Patient/Legal Representative Signature: _____

Date: _____

Printed Name of Parent/Legal Representative: _____

St. Clair Dermatology – HIPAA Privacy Notice

Your Privacy is Important to Us

At St. Clair Dermatology, we are committed to safeguarding the privacy of your protected health information (PHI) as mandated by the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how medical information about you may be used and disclosed, and how you can access this information.

What is Protected Health Information (PHI)?

PHI includes any information about your health status, provision of healthcare, or payment for healthcare that can be linked to you. This includes medical records, treatment plans, insurance claims, and other individually identifiable health information.

How Your PHI May Be Used and Disclosed:

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your healthcare and related services. For example, sharing information with specialists or labs.

Payment: We may use and disclose your PHI for billing purposes, including working with your insurance company to obtain payment for your treatment.

Healthcare Operations: We may use and disclose your PHI for activities such as quality improvement, staff training, and legal compliance.

Your Rights Regarding Your PHI:

Access: You have the right to see, receive a copy of, and request changes to your medical records.

Restrictions: You can request that we communicate with you about your health in a certain way or at a specific location to maintain privacy.

Confidential Communications: You can request that we communicate with you about your health in a certain way or at a specific location to maintain privacy.

Amendment: If you believe your PHI is incorrect or incomplete, you have the right to request changes.

Accounting of Disclosures: You can request a list of certain disclosures of your PHI that we have made.

Our Responsibilities: We are required by law to maintain the privacy and security of your PHI.

We will provide you with a copy of this Privacy Notice and abide by its terms.

We will not use or disclose your PHI without your consent or authorization, except as described in this notice.

Complaints: If you believe your privacy rights have been violated, you can file a complaint with us by contacting our Privacy Officer. You can also file a complaint with the U.S. Department of Health and Human Services.

St. Clair Dermatology – Cancellation and No-Show Policy

As part of our commitment to providing you with the highest quality medical care and ensuring efficient appointment scheduling, we have implemented a Cancellation and No-Show Policy. This policy is designed to optimize appointment availability for all patients while minimizing any inconvenience caused by last-minute cancellations or missed appointments.

Our Cancellation and No-Show Policy: Cancellation Notice: If you need to cancel or reschedule your appointment, we kindly request that you provide at least a 24 hour notice. This allows us to offer the appointment slot to another patient in need of medical attention.

Late Cancellations and No-Shows: Cancellations made with less than 24 hours' notice or missed appointments (no-shows) are subject to a charge, which is not covered by insurance.

Repeated Occurrences: For patients who repeatedly miss appointments or provide late cancellations, we may need to reconsider our ability to continue providing care. It's important that we have a collaborative relationship based on mutual respect for each other's time and commitment.

How to Cancel or Reschedule: To cancel or reschedule your appointment, please call our office at 586-207-2244 or contact us through our website at www.stclairdermatology.com. We understand that unforeseen circumstances can arise, and we appreciate your cooperation in keeping us informed as soon as possible. We value your partnership in maintaining the efficiency and effectiveness of our medical practices. By adhering to this policy, you help us ensure that all patients receive timely and comprehensive care.

If you have any questions or concerns about our Cancellation and No-Show Policy, please do not hesitate to reach out to our office staff. We are here to assist you in any way we can. Thank you for entrusting us with your Dermatology needs. We look forward to continuing to provide you with exceptional medical care.

I acknowledge and understand that St. Clair Dermatology has a policy regarding missed appointments and cancellations.

This policy states that patients who fail to show up for their scheduled appointments or do not provide sufficient notice of cancellation may be subject to a No-Show/Cancellation Fee.

For all Surgical and Cosmetic appointments, a \$200 fee would apply. For all other appointments, a \$75 fee would apply.

I understand that the No-Show/Cancellation Fee cannot be billed to my insurance and I will be responsible for paying this fee to any future appointments

Patient/Agent/Guardian Signature

Date

St. Clair Dermatology - Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy

Name: _____ Phone: _____ City or Zip Code: _____

Past Medical History – Select any of the following medical conditions you currently have:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GERD | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hypertension | <input type="checkbox"/> NONE |
| <input type="checkbox"/> BPH | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypercholesterolemia | _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hyperthyroidism | _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypothyroidism | _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Leukemia | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Cancer | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lymphoma | |

Past Surgical History – Have you had any surgeries on the following organs?

- | | |
|---|--|
| <input type="checkbox"/> Appendix (appendectomy) | <input type="checkbox"/> Ovaries (Oophorectomy): Endometriosis |
| <input type="checkbox"/> Bladder (cystectomy) | <input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cancer |
| <input type="checkbox"/> Breast: Breast Biopsy | <input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cyst |
| <input type="checkbox"/> Breast: Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries: Tubal Ligation |
| <input type="checkbox"/> Breast: Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Pancreas: Pancreatectomy |
| <input type="checkbox"/> Colon (Colectomy): Colon Cancer Resection | <input type="checkbox"/> Prostate (Prostatectomy): Prostate Biopsy |
| <input type="checkbox"/> Colon (Colectomy): Diverticulitis | <input type="checkbox"/> Prostate (Prostatectomy): Prostate Cancer |
| <input type="checkbox"/> Colon (Colectomy): Inflammatory Bowel Disease | <input type="checkbox"/> Prostate (Prostatectomy): TURP |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Rectum: APR |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Skin: Basal Cell Carcinoma |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Skin: Skin Biopsy |
| <input type="checkbox"/> Heart: PTCA | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Joint Replacement: Hip (Right, Left, Bilateral) | <input type="checkbox"/> Testicles (Orchiectomy) |
| <input type="checkbox"/> Joint Replacement: Knee (Right, Left, Bilateral) | <input type="checkbox"/> Uterus (Hysterectomy): Fibroids |
| <input type="checkbox"/> Kidney: Kidney Biopsy | <input type="checkbox"/> Uterus (Hysterectomy): Uterine Cancer |
| <input type="checkbox"/> Kidney: Kidney Stone Removal | <input type="checkbox"/> Uterus (Hysterectomy): Cervical Cancer |
| <input type="checkbox"/> Kidney: Kidney Transplant | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Kidney: Nephrectomy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Liver: Hepatectomy | _____ |
| <input type="checkbox"/> Liver: Liver Transplant | _____ |
| <input type="checkbox"/> Liver: Shunt | |

Skin Disease History – Have you had any of the following?

- Acne
- Actinic Keratosis
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever / Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin cancer
- NONE
- Other:

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of melanoma? Yes No

If yes, which relative?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Uncle
- Aunt
- Nephew
- Niece
- Grandmother
- Grandfather
- Grandson
- Granddaughter
- Other:

Current Medications – List all current medications (please include dosing and frequency):

Allergies – List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker

Start Smoking (mm/dd/yy): _____

Quit Smoking (mm/dd/yy): _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

Driving Status

- Drives in the Daytime
- Drives at Night

How often do you exercise?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other:

What is your Caffeine Usage?

- Once a day
- Several times a day
- A few times week
- A few times a month
- None
- Other:

Occupation and Workplace:

Family History – Please include only first-degree relatives:

Review of Systems – Please indicate all that apply to you today:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Joint aches | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Problems with scarring
(hypertrophic or keloid) | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Rash | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Abdominal pain | | <input type="checkbox"/> Headaches | |

- Allergy to adhesive
- Allergy to lidocaine
- Allergy to topical antibiotic ointments
- Artificial heart valve
- Artificial joints within past two years
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Premedication prior to procedures
- Rapid heartbeat with epinephrine
- Pregnancy or planning pregnancy
- Ebola Risk: Fever ≥ 100.4 degrees (F) / 38.0 degrees (C)
- Ebola Risk: Resided or traveled to country with widespread Ebola transmission in the last 21 days
- Ebola Risk: Contact with Ebola patient without proper protective equipment in the last 21 days
- Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage
- COVID Vaccine

If 66+ years old: Have you received a Pneumonia Vaccine on or after your 60th birthday? Yes No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Yes No

Do you have a living will? Yes No

Which statement(s) best reflects your wishes on advanced care recommendations?

- Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate: if my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Height: _____

Weight: _____