KAREN J. SUNDBY, M.D.

PLEASE COMPLETE THE FOLLOWING *MEDICAL HISTORY FORM*

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ **New** Patient or ☐ **Returning** Patient

FULL LEGAL NAME: _____ **DOB**: _____

Reason for today's visit: ☐ Mohs ☐ Excision ☐ Skin Check ☐ other: _____ Referred by: ☐ self ☐ Dr. _____

History of today's problem only: ☐ NO PROBLEM TODAY

Skin areas involved_____

How long has the problem been present?_____

CHECK ALL THAT APPLY TO TODAY'S PROBLEM **NOT APPLICABLE** ☐

A Change In:	**A History Of:**	**Associated Symptoms**	**Severity**
☐ size	☐ UV light treatments	☐ bleeding	☐ constant symptoms
☐ color	☐ X-ray treatments	☐ tingling	☐ occasional symptoms
☐ elevation	(not routine dental or chest x-ray)	☐ pain	☐ **no symptoms**
☐ hardness	☐ immunosuppression	☐ itching	
☐ **none**	☐ **none**	☐ **none**	

Any previous treatments to this site? ☐ No ☐ Yes, type of treatment? _____ When? _____

Was a biopsy done? ☐ No ☐ Yes, by Dr. _____ Date: _____

Aspirin/blood thinners - last taken: _____

VACCINE **Flu –** Have you had a flu injection this flu season? ☐ No - If yes, when: _____ Given by whom:_____

Pneumococcal – Have you EVER received a Pneumococcal injection? ☐ No - If yes, when: _____ Given by whom:_____

MEDICAL HISTORY PREVIOUS SKIN CANCER: ☐ none ☐ yes/list: Location & Date: _____

MAJOR ILLNESS/ORGAN TRANSPLANT: ☐ no ☐ yes/list: _____

SURGICAL HISTORY ☐ none ☐ yes/reason: _____

HOSPITALIZATION ☐ none ☐ yes/ reason: _____

FAMILY STILL LIVING Check if living (on Brothers and Sisters, please put the number of siblings living or deceased).

Please check all history that applies for living or deceased.

	Living / Deceased	Unknown (Medical History)	Cancer	Melanoma	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness
Father	☐ ☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐ ☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	# ___ living # ___ deceased	☐	☐	☐	☐	☐	☐	☐	☐
Sister	# ___ living # ___ deceased	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐ ☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐ ☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐ ☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐ ☐	☐	☐	☐	☐	☐	☐	☐	☐

Office only: Medical history last completed: _____ ***Date*** _____ ***Initial*** *Revised 9/5/2018*

Patient Label

SOCIAL HISTORY **Occupation**: _____

Alcohol: Did you have a drink in the past year? □ No If **YES**: How often did you have a drink containing alcohol in the past year?

□ Never □ Monthly or less, □ 2 – 4 time a month, □ 2-3 times per week, □ 4 or more time per week.

How many drinks did you have on a typical day when you were drinking in the past year?

□ 1 or 2, □ 3 or 4, □ 5 or 6, □ 7 to 9, □ 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

□ Never □ less than monthly □ Monthly □ Weekly □ Daily or almost daily

Smoking: □ current smoker □ former smoker □ never □ uses tobacco in other forms

If **YES** □ last smoked _____ or □ current smoker

Current Smoker: How often do you smoke Cigarettes □ everyday □ some days, but not everyday

How many cigarettes, do you smoke a day? □ 5 or less, □ 6 – 10 □ 11 – 20, □ 21 – 30, □ 31 or more

How soon after you wake-up do you have your first cigarette? _____.

SYSTEM REVIEW Check ALL that apply regarding your health

SKIN	HEMATOLOGIC/LYMPHATIC	CONSTITUTIONAL SYMPTOM	EYES/EARS/NOSE/THROAT
□ **normal/none**	□ **normal**	□ **none**	□ **normal**
□ abnormal scarring	□ blood transfusions	□ weight loss	□ glaucoma
□ poor healing/scaling	□ bleeding problems	□ fever	□ hearing aid
□ other skin disorders:	□ enlarged lymph nodes	□ other:_____	□ plastic surgery:
_____			_____

CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	MUSCULOSKELETAL
□ **normal**	□ **normal**	□ **normal**	□ **normal**
□ chest pain/Heart attack	□ asthma	□ stomach ulcer	□ arthritis
□ artificial heart valve	□ emphysema	□ colitis	□ artificial joint
□ pacemaker	□ other lung problems:	□ other GI problems:	□ other:
□ hypertension	□ _____	□ _____	□ _____

NEUROLOGICAL	PSYCHIATRIC	ENDOCRINE	INFECTIONS
□ **normal**	□ **normal**	□ **normal**	□ **none** □ other:_____
□ stroke	□ depression	□ diabetes	□ hepatitis
□ seizures	□ anxiety attacks	□ thyroid	□ HIV/AIDS
□ other:_____	□ other:_____	□ other:_____	□ tuberculosis (T.B.)

Office only: All medical history verified: _____ ***Date*** _____ □ ***Initials***

Karen J. Sundby, M.D * 4700 Hale Parkway, Suite 140 * Denver, CO 80220 * Phone: 303-388-8807 * Fax: 303-962-0329

KAREN J. SUNDBY, M.D.
THE MOHS CENTER
FINANCIAL POLICY / HIPAA POLICY

Thank you for choosing our practice. We appreciate your trust in us and the opportunity to serve you. As a part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment.

- Payment for non-covered or cosmetic procedure is due at the time of service.
- We accept cash, check, or credit cards (Visa, Master Card, or Discover)
- An 18% service charge will be added to bills over 30 days old.
- Please note that there will be a no show or late (3 business days) **cancellation fee of $250** for any appointment.

PARTICIPATING PLANS:
We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for any balance due. Co-pay, coinsurance, and deductibles are to be paid on the date of service.

MEDICARE:
We participate with Medicare and accept assignment. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance. We will file a claim with your secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, the patient may be billed.

NON-PARTICIPATING PLANS:
As a courtesy to you we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the balance will be assessed for payment. You should remit payment within 30 days or contact your insurance company to check on the status of the claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim.

KAREN SUNDBY, M.D., AMBULATORY SURGERY CENTER, LLC, DBA THE MOHS CENTER
In some cases, depending on the nature of your surgery, you may be treated in our licensed outpatient surgical center. You and /or your insurance plan may be billed separately for these services. If you have any questions please contact your insurance company or call our office and speak with our billing staff that may be able to help guide you.

OUTSIDE PATHOLOGY OR LABORATORY SERVICES:
If the expertise of an outside lab is needed for a portion of your care (biopsy interpretation, second opinion) you may receive a separate bill from that lab for their services.

USUAL AND CUSTOMARY RATES:
Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this Financial Policy. I understand that it is my responsibility to notify Karen J. Sundby, M.D., P.C of any changes in writing.

X_____ **Date**_____

ACKNOWLEDGEMENT OF HEALTH INFORMATION NOTICE

I am aware of the Notice of Health Information Practices (HIPAA) and understand that this Privacy notice is available upon request.

X_____ **Date**_____

I request that payment of authorized Insurance carrier, or Medicare and/or Medigap be made either to me or on my behalf to Karen J. Sundby, M.D., P.C. for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine benefits payable for services to any insurance company and its agents.

X_____ **Date**_____

By signing this consent, I authorize Karen J. Sundby, M.D., P.C. to release my medical history, including laboratory results to the following family/friends.

☐ **NONE** **Names:** _____ _____ _____

I give Dr. Karen J. Sundby's office permission to leave a message on my voice mail or a secure message on my Patient Portal.
☐ **YES** ☐ **NO** Initial _____

ADVANCE DIRECTIVES: I, the patient, have an Advance Directive: ☐ **YES** ☐ **NO** If yes, please provide us with a copy.

THE PATIENT BILL OF RIGHTS: I have read and understand 'The Patient Bill of Rights' Initial _____

Medication and Allergy List - DO NOT ATTACH LIST

MUST BE FILLED OUT

Prescription* and Over The Counter Drugs

(* If you have any questions, please call your prescribing physician.)

Patient Label

~~ PRINT ONLY ~~ ~~~ PRINT ONLY ~~~ ~~ PRINT ONLY ~~

Patient Name: Date of Birth: Today's Date:

DRUG ALLERGIES: ☐ None

Name of Medication Allergy:	Describe Reaction (hives, rash, nausea, etc.)

MEDICATIONS CURRENTLY TAKING - DO NOT ATTACH LIST

List **ALL** Medications, vitamins, herbal, over the counter, pumps, patches, inhalers, sprays, ointments.

Medication Name (as listed on prescription bottle)	Dosage (# mg, # ml)	Route (mouth, injection)	Frequency (2 x per day, AM & PM)	Diagnosis (reason for medication ie: hypertension, thyroid)

If more space is needed - see page 2 (over)

I acknowledge that this list represents the full extent of all medication I am prescribed and/or taking, to the best of my knowledge. **Patient/Patient Representative: X** _____

~~~ For Office Use Only ~~~ ***Below is for Office Use Only*** ***~~~For Office Use Only ~~~***

New Medication Prescribed Following Your Surgery

Resume all Medications after discharge. If you have any questions, please contact your primary care physician.

X _____

Patient/Patient Representative

There have been no changes to my Medications as of: _____ _____

Date Patient Initial

Karen J. Sundby, M.D. * 4700 Hale Parkway, Suite 140 * Denver, CO 80220 * Ph: 303-388-8807 * Fax: 303-962-0329 9/18/2017

MEDICATIONS CURRENTLY TAKING - *Continued from page 1*

MUST BE FILLED OUT - DO NOT ATTACH LIST

Prescription* and Over The Counter Drugs

(* If you have any questions, please call your prescribing physician.)

Patient Label

~~ PRINT ONLY ~~ ~~~ PRINT ONLY ~~~ ~~ PRINT ONLY ~~

Medication Name (as listed on prescription bottle)	**Dosage** (# mg, # ml)	**Route** (mouth, injection)	**Frequency** (2 x per day, AM & PM)	**Diagnosis** (reason for medication ie: hypertension, thyroid)

I acknowledge that this list represents the full extent of all medication I am prescribed and/or taking, to the best of my knowledge. **Patient/Patient Representative: X** _____

~~~ For Office Use Only ~~~ ***Below is for Office Use Only*** ***~~~For Office Use Only ~~~***

Resume all Medications after discharge. If you have any questions, please contact your primary care physician.

X _____

Patient/Patient Representative

There have been no changes to my Medications as of: _____ _____

Date Patient Initial

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KAREN J. SUNDBY, M.D.

PATIENT DEMOGRAPHICS

Thank you for your help in keeping us current with your information:

PERSONAL INFORMATION:

Appointment Date: _____ DOB _____

Legal Name: _____ Preferred Name: _____

CURRENT ADDRESS – (PHYSICAL ADDRESS):

Street Address: _____

City: _____ State: _____ Zip Code: _____

(Please give us the extended zip code)

MAILING ADDRESS – (if different):

Street Address: _____

City: _____ State: _____ Zip Code: _____

(Please give us the extended zip code)

PLEASE list the following PHONE NUMBERS & *CHECK* your PREFERRED PHONE NUMBER:

☐ Home Phone: _____ ☐ Cell Phone: _____

☐ Work Phone: _____ ☐ Other: _____

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Single ☐ Partner ☐ Widowed

☐ Legally Separated ☐ Unknown

SOCIAL SECURITY NUMBER: _____ *(needed for insurance purposes)*

PRIMARY CARE PHYSICIAN: ***(Must have)***

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

PREFERRED PHARMACY: ***(Must have)***

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone: _____

*** * * OVER * * ***

Patient Label

INSURANCE INFORMATION:

Do you have Medicare? ☐ Yes ☐ No (**If 'No' -** continue to **Primary Insurance**)

Is Medicare your secondary Insurance? ☐ **Yes** (See below) ☐ No (**If 'No' -** continue to **Primary Insurance**)

Why is Medicare your secondary insurance? ☐ Working ☐ Disabled ☐ Other: _____

PRIMARY INSURANCE *(We must have **all** information)*

Insurance Name: _____

- Subscriber's Full Name (***if not patient)***: _____ DOB: _____
- Relationship to Patient: _____
- Address - ☐ Same as Patient's (Address if different from patient): _____

City: _____ State: _____ Zip Code: _____

SECONDARY INSURANCE (*We must have all information)*

Insurance Name: _____

- Subscriber's Full Name (***if not patient)***: _____ DOB: _____
- Relationship to Patient: _____
- Address - ☐ Same as Patient's (Address if different from patient): _____

City: _____ State: _____ Zip Code: _____

EMAIL ADDRESS: _____

Your email address will enable you to access your medical information.

☐ Does not have email ☐ Does not want to be web enabled ☐ Does not want to share email. ☐ Other _____

RACE:

- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race: _____
- ☐ Unreported/Refused to Report - *Initial* _____

LANGUAGE:

- ☐ English
- ☐ Indian (includes Hindi & Tamil)
- ☐ Spanish
- ☐ Russian
- ☐ American Sign Language
- ☐ Refused to Report - *Initial* _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to Report - *Initial* _____

EMPLOYER NAME: ☐ Retired ☐ Not Employed ☐ Student

Company Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Phone number: _____