Dr. Yolanda C Holmes, MD
1140 Connecticut Ave NW, Suite 675
Washington, DC 20036

PATIENT REGISTRATION

First Name _____ Last Name _____

Address _____

Apt # _____ City _____ State _____ Zip Code _____

Home Telephone _____ Cell _____ Work _____

Email Address _____

Sex: Male □ Female □ Date of Birth _____ Race _____

Primary Care MD _____ Phone _____

Emergency Contact _____ Phone _____

INSURANCE INFORMATION

Primary Carrier: _____

Secondary Carrier: _____

PHARMACY INFORMATION

Pharmacy Name _____ Telephone _____

Pharmacy Address _____ Zip Code _____

City _____ State _____

□ *I have read and agree to the Acknowledgement of Financial Responsibility and the Patient Privacy Notice.* Signature: _____

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MEDICAL HISTORY

Patient _____ DOB _____ Today's Date _____

Reason for Today's Visit _____

Do you have or have you had any of the conditions and/or diseases listed?

	Yes	No		Yes	No
Diabetes	☐	☐	Arthritis	☐	☐
Thyroid	☐	☐	Convulsions/Epilepsy/Seizures	☐	☐
Kidney	☐	☐	Fainting	☐	☐
Dialysis	☐	☐	Psoriasis	☐	☐
Bladder Disorder	☐	☐	Lung	☐	☐
Stomach/Colon Disorder	☐	☐			
Cardiovascular:					
High Blood Pressure	☐	☐			
Chest Pain	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Type: _____		
Heart Murmur	☐	☐			
Irregular Heartbeat	☐	☐			
Phlebitis	☐	☐			
Inflammation of Vein	☐	☐			
Blood Clots	☐	☐			
Pacemaker	☐	☐			

List any other conditions and/or diseases: _____

List any surgical procedures you've had in the last 10 years: _____

Do you have any personal or family history of skin cancer? ☐ Yes ☐ No

Do you have problems with healing? ☐ Yes ☐ No

Do you develop keloids (scars) after surgery? ☐ Yes ☐ No

Do you bleed easily or take aspirin/ibuprofen regularly? ☐ Yes ☐ No

Do you develop skin rashes in reaction to: ☐ Medication ☐ Food ☐963Care#

Environment ☐ Bandages

☐ Topical Neosporin Other: _____

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Social History:

Do you drink alcohol? ☐ Yes ☐ No If YES, please circle one: rarely occasionally socially excessively

Do you use recreational drugs? ☐ Yes ☐ No

Do you currently use tobacco? ☐ Yes ☐ No If YES, how often? _____

Have you had or have you been exposed to HIV (AIDS)? ☐ Yes ☐ No

Have you had the flu shot for the current flu season? ☐ Yes ☐ No

If YES, please provide the date of your flu vaccine _____

If NO, please list the reason you have not received the flu shot _____

Have you had the pneumococcal vaccine? ☐ Yes ☐ No

If YES, please provide the name (i.e. PCV13, Prevnar13, PPSV23, or Pneumovax23)

and date of your vaccine _____

If NO, please list the reason you have not received the vaccine _____

Do you have a living will? ☐ Yes ☐ No

Do you have a power of attorney or a healthcare proxy? ☐ Yes ☐ No

If YES, please provide the name: _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Breastfeeding? ☐ Yes ☐ No

Family History: ☐ Hypertension ☐ Cancer ☐ Diabetes ☐ Heart Disease

List all medications you are currently taking (prescriptions, over-the-counter meds, vitamins):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Are you allergic to any medications? ☐ Yes ☐ No If YES, list below:

1. _____ 2. _____

Have you ever had numbing medication? If YES, any bad reactions? ☐ Yes ☐ No

Patient Signature _____ Date _____

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Cosmetic Questionnaire (Optional)

Our goal is to make every patient look and feel as radiant as possible. Washington DC Dermatology is committed to a no-pressure atmosphere where we work with you to achieve your idea of healthy, happy skin.

Tell us if you are experiencing these conditions or are interested in treatment:

- ☐ Acne Scars
- ☐ Age Spots/Liver Spots/Pigmentation
- ☐ Botox/Dysport/Xeomin
- ☐ Chemical Peels
- ☐ Cosmetic Fillers
- ☐ Hyperpigmentation
- ☐ IPL
- ☐ Laser Resurfacing
- ☐ Rosacea/Broken Capillaries
- ☐ Skincare Advice
- ☐ Facials
- ☐ Body Contouring

Share with us any specific concerns or areas for improvement:

_____
_____
_____
_____

What are your current skincare products?

AM Regimen:

Cleanser: _____

Serum: _____

Moisturizer: _____

SPF: _____

Topical Rx: _____

PM Regimen:

Cleanser: _____

Serum: _____

Moisturizer: _____

Eye Cream: _____

Topical Rx: _____

PLEASE DO NOT WRITE ON THIS FORM

Patient Privacy Notice

Dr. Holmes' entire staff values our relationship with you and takes personal privacy seriously. This Privacy Notice explains how we manage the personal and healthcare information that you have provided and how that information is used. Please read this notice carefully.

Information we collect about you: We collect nonpublic personal information about you or your family. We **require** a copy of your insurance card and photo ID. This personal information may include your name, address, telephone numbers, date of birth, Social Security number, and your employer information.

How your information is used: The information you provide is stored and is used to effectively obtain insurance benefits and to provide effective healthcare.

Please note:

- On arrival, you will sign your name on a sign-in sheet. Your name will be called if you are needed at the front desk or if you are being taken to the exam room.
- Your personal health information will be discussed with your physician or another healthcare provider. Information may be requested by your insurance company to properly file a claim. A laboratory may require some of your personal information, however, that is usually limited in nature.
- Your doctor may discuss aspects of your case with one of her colleagues or information may be given to a specialist in order to provide treatment.
- The information you provide may be used to confirm appointments including messages left on answering machines and/or voicemail.

Safeguarding your personal and health information: We restrict access to your personal and health information to only those employees who need to know the information to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulation in order to guard your personal and health information.

Changes to our privacy policy: We occasionally review our privacy policy and reserve the right to amend it. Should our privacy practices change, we will post a copy of the revised notice on our website. You may request and obtain a copy of our Patient Privacy Notice any time you visit our office or view it on our website.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up. This may include multiple healthcare providers who may be involved in my treatment, either directly or indirectly.
- Conduct normal healthcare operations such as quality assessments; and
- View my prescription history from other sources in order to facilitate appropriate medication orders

I understand this practice has the right to change its Patient Privacy Notice and that I may contact this practice at any time to obtain a current copy. I understand that I may request (in writing) restriction or limited use of my health information. I also understand that you are not required to agree to my request, however if agreed, you are obligated to abide with my restrictions.

I may revoke this consent (in writing) at any time, except during which times this practice has already shared information related to my healthcare, in relationship to my signature and date on this consent.

By checking and initialing on my demographic form, I acknowledged receipt of, and agreement to, this practice's Patient Privacy Notice.

PLEASE CHECK BOX AND INITIAL ON PATIENT DEMOGRAPHIC FORM

PLEASE DO NOT WRITE ON THIS FORM

Acknowledgement of Financial Responsibility

I hereby authorize Dr. Yolanda Holmes, MD to release information requested by my insurance carrier, or any person, company, or agency responsible for processing claims for my medical services. I authorize direct payment to Dr. Yolanda Holmes by all insurances or any health plan whose benefits are otherwise payable to me up to the full balance of my medical bills.

I acknowledge that I am FULLY RESPONSIBLE for charges **not** paid by my insurance(s), or any other agency(ies). These charges may include but are not limited to: co-pays, total balances, and collection fees. These collection fees may include attorney fees, court costs, third party billing/credit reporting costs, and may be based on a percentage at a maximum of 25% of the debt.

I understand that I am responsible for providing a referral, if required, at the time of service. If my insurance denies payment for not providing a referral, I am responsible for all costs.

Dr. Yolanda Holmes, MD accepts cash, checks, and major debit/credit cards. There is an additional $30.00 fee for returned checks, which will be added to any existing balance. **I acknowledge that I will be charged a $75.00 fee for office appointments not cancelled within 24 hours of appointment time and/or same day cancellations. A $75.00 fee will also be assessed for NO SHOW appointments.**

By checking and initialing on my demographic form, I acknowledged receipt of, and agreement to this practice's patient financial responsibility policy.

PLEASE CHECK BOX AND INITIAL ON PATIENT DEMOGRAPHIC FORM