Dear Patient,

Welcome to Moeller Dermatology! We are honored you have chosen us for your skin care needs. We have been providing expert medical, surgical and cosmetic dermatologic care to Wichita and surrounding communities since 2001. Our goal is to provide the highest quality of care for all of our patients in a timely and caring manner.

The following information is provided to ensure your first experience with our practice is a positive one:

- You will receive an appointment reminder 3-4 days prior to your appointment. Please confirm your appointment when you receive your reminder.
- Please bring your completed new patient paperwork to your first appointment. If you are unable to complete the paperwork ahead of time, we ask that you arrive at least 15 minutes early to complete the forms in the office.
- At the time of your visit, you will be asked to present the following items:
  - Health insurance card
  - Photo Identification
- If your insurance company requires a referral authorization, request one from your primary care physician. If the insurance referral is not obtained by the time of your appointment, you will be asked to sign a Patient Responsibility Form or reschedule your appointment.
- Co-payments are due at the time of your appointment. For your convenience we accept cash, personal checks, Visa, MasterCard, Discover Card and Care Credit.
- If you are running late, please call the office to let us know. If you arrive 20 minutes or more after your scheduled time, we reserve the right to reschedule your appointment.
- If you are unable to keep your appointment, please call at least 24 hours in advance. Office appointments not canceled or rescheduled with 24 hour notice may be subject to a $50 no show fee, and surgery no shows are subject to a $100 no show fee.

We hope that after your visit you will feel confident that you've made the right decision by choosing our practice. For more information about Moeller Dermatology, visit our website at [www.moellerdermatology.com](http://www.moellerdermatology.com) or call us at 316-682-7546. We look forward to meeting you.

Sincerely,

The Physicians and Staff of Moeller Dermatology
Moeller Dermatology
Patient Information

Patient Demographics

Patient’s Name: ___________________________________________  First  Middle Initial  Last

Home Address: _____________________________________________  Street  Gender: M   F  Marital Status M S D W  Preferred method of contact for reminders: Phone Call   Text   Email

Date of Birth: _____________________  M   F     Marital Status M S D W

Home Phone: ______________________  Work Phone__________________  Cell Phone__________________

Policy Holder Demographics

Policy Holder Name: ___________________________________________  First Name  Middle Int  Last Name  Relationship to Patient:_____________________

Home Address: _____________________________________________  Street  City  State  Zip

Birth Date: _____________________  SSN__________________  Contact #______________________  Employer_____________________

This information must be completed in order to process your claims. If we do not receive this information you could be responsible for payment in full.

☐ Responsible Party for a Minor
Name:_____________________________  Contact Phone:__________________  Relationship:_____________________

☐ Emergency Contact
Name:_____________________________  Contact Phone:__________________  Relationship:_____________________

Referring Physician:_________________________  Primary Care Physician:_________________________

Would you like to receive The Moeller Dermatology Newsletter by email? YES ☐ NO ☐

Acknowledgement of Receipt of Privacy Notice and Receipt of Patient Financial Policy

I acknowledge that I have received a copy of the Provider’s Notice of Privacy Practices with the effective date of August 2016. I also acknowledge that I have received a copy of the current Patient Financial Policy. I understand that the policies are subject to change without notice.

ONE TIME AUTHORIZATION:

I request that payment authorization for Medicare Benefits be made either to me or on my behalf to Moeller Dermatology, LLC for any services furnished to me by the provider. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I hereby assign payments directly to Moeller Dermatology, LLC for any surgical and/or medical benefits. I understand I am financially responsible for charges not covered by my insurance. I also understand that regardless of insurance coverage, I am financially responsible for all services rendered. I authorize Moeller Dermatology to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company.

PHOTOGRAPHS:

I understand that photographs taken before, during, or after the procedure may be used for documentation or teaching purposes.

___________________________________________________  _____________________________
Patient Name (Please Print)  Signature of Patient/Patient Representative  Date

Relationship to Patient

Revised 12/12/18
Patient Authorization to Release
Protected Health Information to Family and Friends
*please note that completing this form is optional*

By signing this authorization, I authorize Moeller Dermatology, LLC to use and/or disclose certain protected health information (PHI) about me to the party or parties listed below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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</tbody>
</table>

This authorization permits Moeller Dermatology, LLC to use or disclose the following individually identifiable PHI:

☒ All Information
☒ Appointment Information Only
☒ Medical Information Only
☒ Account Information Only
☒ Specific Information as described: ____________________________

This authorization will expire two years from the date signed

When my information is used or disclosed according to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that Moeller Dermatology, LLC has acted in good faith upon this authorization. My written revocation must be submitted to Moeller Dermatology, LLC ATTN: Privacy Officer, 1911 N Webb Road, Wichita, KS 67206.

Patient Name

Signature of Patient or Legal Guardian Date

Printed name of Patient or Legal Guardian Relationship

Office Staff Signature Date

Yearly Update Patient/Legal Guardian and Staff Initials Date

Yearly Update Patient/Legal Guardian and Staff Initials Date

Yearly Update Patient/Legal Guardian and Staff Initials Date

Updated 12/2018
History and Intake Form

Past Medical History: (please circle all that apply)

- Alzheimer's
- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation (Irregular Heartbeat)
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease

Other: _______________________________________________________________________________________

Past Surgical History: (please circle all that apply)

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy (Right, Left, Bilateral)
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast: Mastectomy (Right, Left, Bilateral)
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Colon: Colostomy (insertion of colostomy bag)
- Gallbladder (Cholecystectomy)
- Heart: Biological Valve Replacement
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- Joint Replacement: Knee (Right, Left, Bilateral)
- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Liver: Shunt
- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR (Abdominoperineal resection)
- Rectum: Low Anterior Resection
- Skin: Basal Cell Cancer Surgery
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer

Other: _______________________________________________________________________________________

3/5/2019

(continues on reverse)
Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
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(s)? ___________________________________________________________________

Medications: (Please enter all current prescriptions and over the counter medications including dosage)
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

Allergies: (Please enter all allergies and reactions)
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

Social History: (Please circle all that apply)

Smoking Status:                                                                                   Caffeine Use:
Current everyday smoker                                                                    Several times a day
Current some day smoker/tobacco use                                                              Once a day
Former smoker/tobacco user                                                                      Few times a week
Started smoking: __________ packs per day: ___                                                   Few times a month
Quit smoking: ___________________                                                             Never
Has never smoked

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Exercise:
Several times a day
Once a day
Few times a week
Few times a month
Never

Occupation/Workplace:  ____________________________________________________________________________

Place of residence:   Home_____ School Housing_____ Assisted Living/Nursing_____ Other_____

Preferred Pharmacy:  ____________________________________________________________________________

3/5/2019
(continues on reverse)
Review of Systems: Are you **currently** experiencing any of the following?  
(Please check **yes** or **no** for the following)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
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<tr>
<td>Allergies</td>
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<tr>
<td>Anxiety</td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Bloody stool</td>
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<tr>
<td>Bloody urine</td>
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<tr>
<td>Blurry vision</td>
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<tr>
<td>Cataracts</td>
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<tr>
<td>Change in body hair</td>
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<tr>
<td>Change in facial hair</td>
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<tr>
<td>Chest pain</td>
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<tr>
<td>Cough</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Diarrhea</td>
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<tr>
<td>Enlarged glands</td>
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<tr>
<td>Eyelid dermatitis</td>
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<tr>
<td>Fatigue</td>
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<td>Fever</td>
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<tr>
<td>Flushing</td>
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<tr>
<td>Hay fever</td>
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<tr>
<td>Headaches</td>
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<tr>
<td>Immunosuppression</td>
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<tr>
<td>Lumps</td>
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<tr>
<td>Mouth Sores</td>
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<tr>
<td>Muscle weakness</td>
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<tr>
<td>Neck stiffness</td>
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<tr>
<td>New medications</td>
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<tr>
<td>Night Sweats</td>
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<tr>
<td>Problems with bleeding</td>
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<tr>
<td>Problems with healing</td>
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<tr>
<td>Problems with scarring</td>
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<tr>
<td>Rash/sores/blisters</td>
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<tr>
<td>Recent fever</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Shortness of breath</td>
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<tr>
<td>Skin infections</td>
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<tr>
<td>Sore joints</td>
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<td>Sore throat</td>
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<td>Stretch marks</td>
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<td>Sun sensitivity</td>
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<td>Thyroid problems</td>
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<tr>
<td>Unintentional weight loss</td>
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<tr>
<td>Vomiting</td>
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<tr>
<td>Wheezing</td>
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(continues on reverse)
Alerts: Special instructions we may need to know.
(Please check yes or no for the following)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Allergy to adhesive</td>
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<tr>
<td>Allergy to lidocaine</td>
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<tr>
<td>Allergy to topical antibiotic ointments</td>
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<tr>
<td>Artificial heart valve</td>
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<tr>
<td>Artificial joints within past two years</td>
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<tr>
<td>Blood thinners</td>
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<tr>
<td>Defibrillator</td>
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<td>MRSA</td>
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<tr>
<td>Pacemaker</td>
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<td>Pregnant or planning a pregnancy</td>
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<tr>
<td>Premedication prior to procedures</td>
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<tr>
<td>Rapid heartbeat with epinephrine</td>
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<tr>
<td>Other:</td>
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</table>

Skin Enhancement Center
Are you interested in discussing skincare products and/or cosmetic procedures that will improve the health and appearance of your skin? Yes No
If yes, what are your concerns? (Please circle all that apply)
Acne      Scars
Aging     Skincare
Dark spots Skin elasticity
Dry skin   Skin texture
Excessive sweating Redness
Hair reduction Unwanted tattoo
Loss of facial volume Wrinkles