James R. Wharton, M.D.
13802 Lake Point Circle Louisville, Kentucky 40223
(502)245-4450 and (502)855-6200

Aesthetics Center of Louisville
James R. Wharton, MD

GENERAL INFORMATION

Patient Name_____ **Primary Care Physician**_____

Social Security Number_____

Date of Birth ____/____/____ **Age**_____ **Sex**_____ **Height**_____ **Weight**_____

Address_____
Street City State Zip

Preferred Phone: Home OR Cell

Home Phone_____ **Cell Phone**_____ **Work Phone** _____

Employer_____ **Email**_____

Emergency Contact: Name & Phone Number_____

INSURANCE INFORMATION (Please present insurance cards and photo ID to the receptionist):

Do you have health insurance? Yes ___ No ___

Insurance Subscriber information (if not the patient)

Name_____ Relationship to patient _____

Date of Birth ____/____/____ Social Security Number_____

Home Phone_____ Work Phone_____ Cell Phone_____

Preferred Method of Contact:
For the purposes of providing results in a more timely manner, I grant Louisville Dermatology and Aesthetics Center of Louisville permission to provide general correspondence, pathology and lab results, via secure voicemail, on the number listed below.

Phone Number: (___)_____-_____

☐ I decline to receive my results via voicemail

I authorize the providers to perform diagnostic procedures and treatment as may be necessary for proper medical care. I understand that as part of the medical procedures or tests relating to my medical care, I may be tested for human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if a provider orders the test for diagnostic purposes. I authorize James R. Wharton, M.D., PSC, to release any medical information including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such care to third party payers and other health practitioners. I authorize and assign directly to James R. Wharton, M.D., PSC all medical benefits, if any, otherwise payable to me for services rendered. In the event I have a skin biopsy, I consent to having my biopsy sent to the pathologist my doctor determines is most appropriate for arriving at an accurate diagnosis of my condition. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is turned over to collection agency, I understand that financial records and information will be submitted for collection processing and I will be responsible for up to a 40% surcharge in addition to my balance. I have received a copy of James R. Wharton, M.D., PSC's Notice of Privacy Practices.

_____ _____
Patient or Responsible Party Signature Date

MEDICAL HISTORY

NAME _____ DATE _____

Past Medical History: (Please circle all that apply): **NONE**

Anxiety	Coronary Artery Disease	HIV/AIDS	Seizures
Arthritis	Depression	High Cholesterol	Stroke
Asthma	Diabetes	Hyperthyroidism	Tuberculosis
Atrial fibrillation	End Stage Renal Disease	Hypothyroidism	
Bone Marrow Transplantation	GERD	Leukemia	
Breast Cancer	Hearing Loss	Lung Cancer	
Colon Cancer	Hepatitis	Prostate Cancer	
COPD	High Blood Pressure	Radiation Treatment	

Other:_____

Past Surgical History: (Please circle all that apply): **NONE**

Appendix Removed	Mechanical Valve Replacement	Ovaries Removed: Endometriosis
Bladder Removed	Biological Valve Replacement	Ovaries Removed: Cyst
Mastectomy (Right, Left, Bilateral)	Heart Transplant	Ovaries Removed: Ovarian Cancer
Lumpectomy (Right, Left, Bilateral)	Joint Replacement, Knee (Right, Left, Bilateral)	Prostate Removed: Prostate Cancer
Breast Biopsy (Right, Left, Bilateral)		Prostate Biopsy
Breast Reduction	Joint Replacement, Hip (Right, Left, Bilateral)	TURP (Prostate Removal)
Breast Implants		Spleen Removed
Colectomy: Colon Cancer Resection	Joint Replacement within last 2 years	Testicles Removed(Right, Left, Bilateral)
Colectomy: Diverticulitis	Kidney Biopsy (Nephrectomy)	Hysterectomy: Fibroids
Colectomy: IBD	Kidney Removed (Right, Left)	Hysterectomy: Uterine Cancer
Gallbladder Removed	Kidney Stone Removal	
Coronary Artery Bypass	Kidney Transplant	

Other:_____

Skin Disease History: (Please circle all that apply): **NONE**

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

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)? _____

Current Medications: NONE

Medication Name

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

Drug Allergies: NONE

Name of Drug	Type of reaction (rash, hives, nausea, etc.)
1._____	
2._____	
3._____	
4._____	
5._____	

Social History (please circle all that apply)

Cigarette Smoking:

Never Smoked
Has smoked in the past
Former Smoker
Currently Smokes

Alcohol Use

EtOH- None
EtOH- Less than 1 drink per day
EtOH- 1-2 Drinks per day
EtOH- 3 or more drinks per day

In the last year, on more than two occasions, have you consumed more than four (if female) or five (if male) drinks in a day? YES NO

Other:_____

Information entered, reviewed, and signed by provider in EHR

NAME _____ **DATE** _____

General Family Medical History (Only first degree relatives)

_____

_____

How were you referred to our office? (Patient - Doctor)_____

Preferred Pharmacy Name: _____ Phone Number: _____
City, Zip Code: _____

I give my consent for Louisville Dermatology Clinic to import my pharmacy data from my Surescripts pharmacy **YES NO**

Preferred Language: _____ Race: _____ Ethnic Group: _____

What is the primary reason for your visit today?_____

Review of Systems: Are you currently experiencing any of the following? (Please check yes or no for the following)

Symptoms	Yes	No
Problems Bleeding		
Problems Healing		
Problems Scarring		
Rash		
Immunosuppression		
Hay Fever		
Chest Pain		
Fever or Chills		
Night Sweats		
Unintentional Weight Loss		
Thyroid Problems		
Swollen Lymph Nodes		
Sore Throat		
Blurry Vision		
Abdominal Pain		
Bloody Stool/Urine		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Headaches		
Seizures		
Cough		
Shortness of Breath		
Wheezing		
Anxiety		
Any Newly Pigmented Lesions		
Depression		

Alerts: (Please circle all that apply):

Allergy to Adhesive

Allergy to Lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joint replacement

Blood thinners

Defibrillator

MRSA

Pacemaker

Require antibiotics prior to a surgical procedure

Rapid heartbeat with epinephrine

Are you pregnant or currently trying to get pregnant?

NONE OF THE ABOVE APPLY

Have you received an influenza vaccine in the past year?
YES NO
If yes, approximate date: _____

Have you ever received a Pneumonia vaccine?
YES NO
If yes, approximate date: _____

Do you have an advance care plan or surrogate decision maker? **YES NO**
If yes, my surrogate decision maker name & relationship to myself is: _____

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AUTHORIZATION FOR MARKETING PURPOSES FOR AESTHETICS CENTER OF LOUISVILLE

☐ I decline to receive communication via email correspondence for marketing purposes
☐ I agree to receive communication via email correspondence for marketing purposes

HIPAA applies to "PHI" (Protected Health Information). This is information that identifies who the health-related information belongs to, i.e. names, email addresses, phone numbers, medical record numbers, photos, driver's license numbers, etc. If you have something that can identify a user together with health information of any kind (from an appointment, to a list of prescriptions, to test results, to a list of doctors) you have PHI that needs to be protected under HIPAA guidelines.
In an effort to update our privacy policies consistent with the new HIPAA guidelines for marketing purposes, we are requesting that all of our patients resubmit their request to receive emails from our practice regarding news, events, products, services and other marketing materials. Please read below the updated regulations for obtaining authorizations for marketing purposes.
I give permission to Aesthetics Center of Louisville and Louisville Dermatology Clinic to send emails for marketing purposes. I understand that my signature below permits this disclosure with no such expiration date. I understand by signing I am agreeing to allow Aesthetics Center of Louisville and Louisville Dermatology Clinic access to PHI including my name, email address and potentially mailing address for the purpose of marketing the practice and services offered. I understand that I have the right to revoke this authorization, at any time, by unsubscribing from the email list. This correspondence may lead to remuneration for the practice. We respect your privacy and do not sell your information to third parties. Although we do not anticipate additional disclosures, due to the nature of the email transmissions, by releasing your information, other disclosures may occur and that PHI may no longer be protected by the Privacy Rule. In terms of shared medical information, treatment may not be conditioned on receipt of the authorization, or under the circumstances where it can be conditioned such as for research purposes.
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Signature Date
Email Address _____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

I authorize James R. Wharton, M.D., PSC, to release mine or my child's medical information to the individual(s) listed below: (ex. Spouse , sibling, parent, etc)

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED:

Patient/Guardian Signature: _____ Relationship: _____

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Missed Appointment Policy

We're glad you have chosen us to provide your medical care, but if you miss your appointments, you inconvenience not only the staff but those individuals who need access to medical care in a timely manner. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show up for an appointment without a phone call, or cancel without at least 24-hour notice.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the courtesy of a call when you are unable to keep your appointment. Below, our missed appointment policies are outlined.

Let's work together to provide you with the best possible care you deserve.

Routine Office Visits

1. 1st Missed Appointment: You may reschedule your appointment.
   You may be charged a missed appointment fee of $25.
2. 2nd missed Appointment: You may reschedule your appointment.
   You may be charged a missed appointment fee of $25.
3. 3rd Missed Appointment: You will be charged a missed appointment fee of $25.
   This may result in a discharge from the practice.

Office Procedure Appointments

1. 1st Missed Appointment: You may reschedule your appointment.
   You will be charged a missed appointment fee of $150.
2. 2nd missed Appointment: You may reschedule your appointment.
   You will be charged a missed appointment fee of $150.
3. 3rd Missed Appointment: This may result in a discharge from the practice.
   You will be charged a missed appointment fee of $150.

Authorization / Assignment / Financial Responsibility

I understand that I am financially responsible for all charges. There are some procedures that require a deposit prior to the treatment date or are cosmetic procedures not billable through insurance. All procedures needing a deposit will be discussed with patient prior to scheduling. I understand that all sales and purchases are final.

My Signature below indicates that I have read and am in agreement with all above statements.

Print Name: _____

Signature: _____ **Date:** _____