Jennifer Pennoyer, M.D., L.L.C.
47 Jolley Drive
Bloomfield, CT 06002

P	Patient Name (LAST, FIRST, MIDDLE INITIAL)		Email address Can we email you? YES NO	
A	Address		Pharmacy name and address	
T	City	State	Zip	
I	Home Phone	Date of Birth	Last 4 of Soc Sec #	Marital Status
E	Employer		Business Phone	
N	Employer's Address City		State	Zip
T	Primary Care Physician Name		Emergency Contact Name/Phone #/Relationship	

I	Primary Insurance	Effective Date	Indentification Number	Group #
N	Policy Holder Name	Relationship	Date of Birth	Occupation/Title
S	Secondary Insurance	Effective Date	Indentification Number	Group #
U	Policy Holder Name	Relationship	Date of Birth	Occupation/Title
R				
A				
N				
C				
E				

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/Other Insurance company benefits be made to either me or on my behalf to Jennifer W. Pennoyer, M.D. for any services furnished me by that party who accepts assignment /physician.
Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Heath Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying in my treatment.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have received a copy of this practice's *NOTICE OF PRIVACY PRACTICES*.
I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

☐ Patient Refused to Sign

☐ Patient was unable to sign because _____

Signature: _____ Date: _____

History and Intake Form Name: _____ Date of birth: _____

Pharmacy: _____ Primary Care Physician: _____

Past Medical History: (Circle all that apply)

Have you had the Pneumonia vaccination? YES NO Have you had the Influenza vaccination? YES NO

Arthritis	Coronary Artery Disease	HIV or Aids	Lymphoma
Asthma	Diabetes	High Cholesterol	Radiation Treatment
Atrial Fibrillation	End Stage Renal Disease	Hyperthyroid	Seizure disorder
Bone Marrow transplant	Hepatitis	Hypothyroid	Other:

Past Surgical History: (Circle all that apply)

Mechanical or Biological Valve Replacement	Joint Replacement in past 2 years. Which joint?	Spleen removed Other:

Skin Disease History: (Circle all that apply)

Acne	Blistering Sunburns	Hay fever/ Allergies	Psoriasis
Actinic Keratosis	Eczema	Melanoma	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Flakey or Itchy Scalp	Precancerous Moles	Other:

Do you wear Sunscreen? YES NO *If yes, what is the SPF? _____

Do you currently use a tanning Bed? YES NO *Have you used a tanning bed in the past? YES NO

Do you have a family history of Melanoma? YES NO *If yes, who? _____

Medications: (List or provide a list to copy)	**Allergies: (List all Allergies)**

Social History: (Circle all that Apply)

Cigarette Smoking? Current / Past / Never	Alcohol Use? None / Less than 1 a day / 1-2 a day / 3 or more a day

Preferred Language: _____ Race: _____ Ethnic Group: _____

Occupation: _____

Alerts: (Circle all that Apply)

Do you have Advanced Care Directive? _____ Who is your Proxy? _____

Allergy to adhesive tape	Artificial joint replacement	Defibrillator	Blood thinners
Allergy to Lidocaine	Artificial heart valve	MRSA	Pacemaker
Allergy to topical antibiotic	Require antibiotic prior to surgery	Rapid heart rate with Epinephrine	Pregnant or trying to get pregnant

PENNOYER MD DERMATOLOGY
Jennifer W. Pennoyer, MD
Lynn M. Fairchild, PA-C
Jesse E. Hill, PA-C
Kelly O. Smith, PA-C
47 Jolley Drive
Bloomfield, CT 06002

HIPAA PATIENT COMMUNICATION FORM

It is the office policy of Pennoyer MD Dermatology not to release confidential medical information regarding your treatment to family members or friends, except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends or caretakers/babysitters, please indicate that below.

By signing below, you authorize the following people to receive information regarding your treatment:

List names (please list relationship such as spouse, parent, boyfriend, girlfriend, sister, brother, etc.)

_____

_____

How may we contact you?

Home Phone _____	Cell Phone_____	Work Phone_____
___ DO NOT leave a message	___ DO NOT leave a message	___ DO NOT leave a message
___ Leave a brief message	___ Leave a brief message	___ Leave a brief message
___ Leave a detailed message	___ Leave a detailed message	___ Leave a detailed message

****WHICH PHONE NUMBER WOULD YOU LIKE AS YOUR PRIMARY NUMBER _____****

Who would you like us to contact in case of emergency:

Name: _____ Relationship: _____

Phone Number: _____

If you wish to add names later on, please confirm in writing or call our staff directly.

Patient's Printed Name: _____ **Patient's DOB**: _____

Patient's Signature: _____

Parent/Guardian Signature: _____

Today's Date: _____