Safe
Dermatology

New Patient Paperwork

Safe Health PC dba Safe Dermatology | Saif Fatteh, MD
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Please complete all sections that apply. If a question does not apply, write "N/A." You can type directly into this form on a computer, then save it. Return it by fax to (844) 749-3800 or bring it to your appointment. Please also bring a photo ID and your current insurance card(s). If the patient is under 18, a parent or legal guardian should complete and sign this form.

PATIENT INFORMATION

Legal first name | Middle | Legal last name | Preferred name

Date of birth (MM/DD/YYYY) | Sex | Pronouns (optional) | Preferred language

Street address | Apt / Unit

City | State | ZIP | County

Mobile phone | Home / other phone | Email

APPOINTMENT, REFERRAL & PHARMACY

Reason for visit | Appointment date

Referring provider (if any) | Primary care provider

Preferred pharmacy (name and city) | Pharmacy phone

1. CONTACT & RESPONSIBLE PARTY

Emergency Contact

Emergency contact name | Relationship | Phone | Alternate phone

Parent / Legal Guardian / Personal Representative (if applicable)

Guardian name | Relationship to patient | Guardian phone

Guardian email | Guardian address (if different)

Authority / notes (e.g., custody, power of attorney)

Responsible Party / Guarantor (person responsible for the bill, if not the patient)

Guarantor name | Relationship | Guarantor date of birth | Guarantor phone

Guarantor address | Employer (optional)

Communication Preferences (check all that are OK)

☐ Phone call ☐ Voicemail ☐ Text message ☐ Email ☐ Patient portal ☐ Mail

Preferred phone number

Preferred email

2. INSURANCE & BILLING

Insurance coverage is determined by your plan. Verification of benefits is not a guarantee of payment. You may be responsible for deductibles, copayments, coinsurance, non-covered services, and other amounts permitted by law and our financial policies. Safe Dermatology does not accept Medicaid or Medicaid health plans.

Primary Insurance

Primary insurance company

Member / ID #

Group #

Plan name

Subscriber name

Subscriber DOB

Relationship to patient

Subscriber employer

Secondary Insurance (if any)

Secondary insurance company

Secondary member / ID #

Secondary group #

Secondary plan name

Secondary subscriber name

Secondary subscriber DOB

Secondary relationship

Secondary subscriber employer

- ☐ I will notify the practice of changes to my insurance or contact information.
- ☐ I authorize submission of claims and information reasonably necessary for payment, as permitted by law.
- ☐ I understand cosmetic or other non-covered services may be my financial responsibility.
- ☐ I understand this form does not guarantee insurance coverage or reimbursement.

3. MEDICAL HISTORY

Medical Conditions (check all that apply)

- ☐ Acne
- ☐ Actinic keratoses
- ☐ Allergies / hay fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding disorder
- ☐ Cancer / history of cancer
- ☐ Diabetes
- ☐ Eczema / dermatitis
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seizures
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer / GI disease
- ☐ Immunosuppression
- ☐ History of blood clots

Other medical conditions

Past Medical / Surgical History

Surgeries / procedures

Hospitalizations

Major illnesses

Skin cancer history

Other significant history

Family History (check all that apply)

- ☐ Skin cancer
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Eczema / atopic disease

☐ Autoimmune disease ☐ Other cancer ☐ No significant family history

Family history details (who and what)

4. MEDICATIONS & ALLERGIES

Current Medications

Include prescriptions, over-the-counter medicines, vitamins, supplements, creams and ointments, injections, and as-needed medicines.

Medication / supplement	Dose	How often	Reason	Prescriber

Medication Allergies

☐ No known medication allergies

Medication allergy 1 / reaction

Medication allergy 2 / reaction

Medication allergy 3 / reaction

Other Allergies / Sensitivities

☐ Latex ☐ Adhesives / tape ☐ Cosmetics / skincare products

☐ Foods ☐ Local anesthetics ☐ None known

Other allergies: details / reactions

Blood Thinners / Bleeding Risk

☐ I do not take blood thinners or medicines that affect bleeding.

Blood thinner medication(s)

Do not stop a prescribed medication because of this form. Discuss any medication changes with the prescribing clinician.

5. DERMATOLOGY HISTORY

Current Skin Concerns

Concern 1: location / description

Concern 2: location / description

Concern 3: location / description

Symptoms

☐ Itching ☐ Pain ☐ Burning ☐ Bleeding

☐ Scaling ☐ Crusting ☐ Drainage ☐ Changing size/shape/color

☐ None

History of Skin Conditions

☐ Acne ☐ Rosacea ☐ Eczema / dermatitis ☐ Psoriasis ☐ Hives

- [ ] Warts
- [ ] Cold sores
- [ ] Fungal infection
- [ ] Hair loss
- [ ] Excess hair growth
- [ ] Nail disease
- [ ] Skin cancer
- [ ] Melanoma

Other skin conditions

Skin Cancer / Lesion History

Prior skin cancer?	☐ No	☐ Yes	Type:	
Prior melanoma?	☐ No	☐ Yes	Year / location:	
Prior biopsies?	☐ No	☐ Yes	Approximate number:	

Sun & Tanning History

- [ ] Frequent sun exposure
- [ ] History of blistering sunburns
- [ ] Indoor tanning
- [ ] Regular sunscreen use
- [ ] Outdoor occupation / recreation
- [ ] None of these

Typical sunscreen SPF / product (optional)

6. SOCIAL & REPRODUCTIVE HISTORY

Social History

- [ ] Never smoker
- [ ] Former smoker
- [ ] Current smoker
- [ ] Vaping / nicotine use
- [ ] No tobacco / nicotine use
- [ ] Alcohol use
- [ ] Recreational drug use

Occupation

Relevant occupational / environmental exposures

Pregnancy / Breastfeeding (if applicable)

- [ ] Not applicable
- [ ] Not pregnant
- [ ] Pregnant
- [ ] Trying to become pregnant
- [ ] Breastfeeding
- [ ] Unsure / would like to discuss

Last menstrual period (if applicable)

Estimated due date (if applicable)

Gender Information (optional)

Collected to support respectful communication and appropriate clinical care.

Gender identity (optional)

7. REVIEW OF SYSTEMS

Check any symptoms you currently have.

- [ ] Fever / chills
- [ ] Unexplained weight loss
- [ ] Fatigue
- [ ] Vision changes
- [ ] Headaches
- [ ] Chest pain
- [ ] Shortness of breath
- [ ] Cough
- [ ] Abdominal pain
- [ ] Nausea / vomiting
- [ ] Joint pain / swelling
- [ ] Muscle weakness
- [ ] Easy bruising / bleeding
- [ ] Swollen lymph nodes
- [ ] Depression / anxiety symptoms
- [ ] Frequent infections
- [ ] Thyroid symptoms
- [ ] Other

Details, or anything else you want the doctor to know

8. GENERAL CONSENT TO DERMATOLOGIC CARE

I consent to evaluation and treatment by Safe Health PC dba Safe Dermatology and its physicians and other qualified healthcare professionals, as appropriate. Care may include examination of the skin, hair, nails, mucous membranes, and other relevant areas; diagnostic testing; laboratory or pathology testing; medications; injections; biopsies; lesion treatment or removal; and other medically appropriate services.

The specific risks, benefits, alternatives, and expected outcomes of procedures requiring informed consent will be discussed before those procedures are performed. This general consent does not replace a procedure-specific consent when one is required.

- ☐ I have had an opportunity to provide my medical history and ask questions.
- ☐ I understand that no particular medical or cosmetic result can be guaranteed.
- ☐ I understand that I should tell the clinician about medications, allergies, pregnancy, prior reactions, and relevant medical conditions.
- ☐ I understand that I may ask questions or decline a proposed treatment, subject to applicable law and clinical circumstances.

Clinical Photography

Clinical photographs may be taken when appropriate to document a condition, treatment, or progress and may become part of my medical record. Separate authorization will be requested for any marketing, advertising, publication, or other public use.

- ☐ I understand the clinical photography statement above.

Telehealth / Electronic Communication

Telehealth (video visits) and electronic communications have limitations. The practice may recommend an in-person examination when clinically appropriate. Electronic communications may carry privacy or security risks. For video visits, I must be located in Michigan at the time of the visit.

- ☐ I understand the telehealth / electronic communication statement above.

9. PATIENT ACKNOWLEDGMENTS & SIGNATURE

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that incomplete or inaccurate information may affect my care. I agree to notify Safe Dermatology of significant changes to my medications, allergies, medical history, contact information, or insurance information.

- ☐ I received or was offered the HIPAA Notice of Privacy Practices.
- ☐ I reviewed the HIPAA Acknowledgment & Authorization.
- ☐ I received or reviewed the No-Show / Missed Appointment Policy.
- ☐ I understand that insurance coverage is determined by my plan and that I may be responsible for permitted patient balances.
- ☐ I understand that procedure-specific consent may be required before certain treatments.

Patient name (print) | Date

Signature of patient or authorized representative (type full name to sign)

Representative name / relationship (if signing for the patient) | Representative authority (if applicable)

OFFICE USE ONLY

Staff name / initials | Date reviewed | In DrChrono (Y/N) | Items requiring follow-up