William J. Helms, M.D.
Dermatology Clinic

First:_____MI:_____Last:_____DOB:_____

Gender:_____Race:_____Ethnicity:_____SSN:_____

Preferred Language:_____Email:_____

Home Phone:_____Cell Phone:_____

Address:_____

City/State:_____Zip Code:_____

Preferred Pharmacy:_____

Primary Physician:_____Referring Physician:_____

Emergency Contact:

Name: _____Relation: _____Phone: _____

IINSURANCE INFORMATION

Primary Insurance_____

Insurance Address_____

ID# _____Group#_____

Policy Holder:_____DOB_____

Relationship to Policy Holder_____

Secondary Insurance_____

Insurance Address_____

ID#_____Group#_____

Policy Holder:_____ DOB_____

Relationship to Policy Holder_____

I am a patient of William J. Helms, M.D. Dermatology Clinic. I hereby acknowledge receipt of Helms Dermatology's Notice of Privacy Practices.

Name (Please Print) _____

Signature _____Date _____

OR

I am a parent or legal guardian of _____(patient name). I hereby acknowledge receipt of Helms Dermatology's Notice of Privacy Practices with respect to the patient.

Name (Please Print)_____

Relationship to Patient: _____Parent _____Legal Guardian

Signature _____Date_____

The following individual(s) may receive my protected health information (PHI)

_____

_____

_____

William J. Helms, M.D.
Dermatology Clinic
P.O. Box 804
Russellville, AR 72811
(479) 968- 8940 Fax: (479) 968-8901

No Call/No Show Policy

As a courtesy, we call to confirm your appointment at least 1 day prior to the scheduled time. Please make sure we have the accurate telephone number you would like us to call with the reminder. Patients must cancel or reschedule appointments at least 12 hours in advance of the scheduled appointment. Patients will be considered for dismissal from the practice after 3 No Call/No Shows. As a courtesy, we call 1 to 2 days prior to your scheduled appointment to remind you of the date and time. We require that you cancel or reschedule your appointment at least 12 hours in advance. With prior notice we can offer the appointment time we had set aside for you to another patient that may have an urgent need to see the provider. Thank you, in advance, for helping us accommodate all our patients by cancelling your appointment if you are unable to keep your scheduled time. If you have questions regarding this policy, you may contact our Office Manager, Donna Howell at (479)968-8940.

As a courtesy to our patient, we file insurance claims for all visits and services rendered. Your insurance is a contract between you and the insurance company, we are not part of that contract. It is your responsibility to know and understand the provisions of your medical insurance policy. Our office cannot guarantee payment of your claims; benefits and payments are determined by the insurance carrier at the time of claim submission. If you disagree with your carrier's determination; all carriers have a patient claim appeal process. You can expect to receive a bill for all deductibles, co-insurances, non-paid an/or non-covered services that your carrier has determined to be patient responsibility. Co-pays are due at the time of service. It is your responsibility to know your insurance plan's provisions and seek appropriate approval prior to your services, as coverage varies by insurance company and can vary from policy to policy.

If we do not participate with your insurance company, or if you do not have medical insurance coverage, payment for services is due at the time services are rendered. We accept cash, personal checks, money orders, Visa, MasterCard, and Discover. Any personal check that is returned for insufficient funds is subject to a $25 service fee. In the event there is a balance due from you after your claim is processed. We will send a billing statement to you for payment in full within 15 days. Patient balances older than 60 days will be reviewed by Dr. Helms and may be referred to an outside collection agency. Payment plan options may be available for some balances. Contact our office at (479)968-8940 for further information. Patients with a past due balance must make payment arrangements prior to scheduling any further appointments.

At Helms Dermatology we are committed to providing our patients with the best possible dermatology care. As a patient, your clear understanding of our policy is important to our professional relationship.

I understand and agree that the practice and/or collection agency retained by Helms Dermatology may contact me by telephone and/or email provided by me or associated with my account. All fees associated with cellular/wireless calls or text messages are my responsibility. Collection contact may also be made by automatic dialing devices and/or through pre-recorded messages, artificial voice messages, or voicemail messages.

_____ _____

PATIENT/Guardian Signature Date

William J. Helms, M.D.
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P.O. Box 804
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Name:_____

Vaccination Record

Pneumonia Vaccination: (Yes/No) Date: _____FLU Vaccination: (Yes/No) Date: _____

COVID Vaccination: (Yes/No) Date: _____

(65 and Older ONLY) Do you have a health care proxy: (Yes/No) If yes, who?_____

Do you have a living will? (Yes/No)

MEDICAL HISTORY

Date of Birth: _____ Reason for Visit: _____

Have you had or do you have any of the following conditions?

☐ Arthritis ☐ Depression ☐ Hepatitis (B or C) ☐ Seizures

☐ Atrial Fibrillation ☐ Diabetes ☐ HIV/AIDS ☐ Stroke

☐ Coronary Artery Disease ☐ COPD ☐ High Cholesterol ☐ Thyroid disorder

☐ Cancer: _____ ☐ Hypertension/High Blood Pressure

☐ Pregnant or planning a pregnancy ☐ Premedication prior to procedures ☐ Rapid heartbeat with epinephrine?

Have you had any of the following surgeries?

☐ Heart: Replace Biological Valve ☐ Heart: Replace Mechanical Valve ☐ Heart: PTCA (Stents)

☐ Heart: Coronary Artery Bypass ☐ Ovaries: Tubal Ligation ☐ Uterus: Hysterectomy

☐ Joint Replacement: Hip (R/L) ☐ Joint Replacement: Knee (R/L ☐ Defibrillator

☐ Pacemaker ☐ Other: _____

Skin Disease History:

☐ Acne ☐ Actinic Keratosis ("pre-cancers") ☐ Basal Cell Skin Cancer ☐ Squamous Cell Skin Cancer

☐ Dry Skin ☐ Eczema ☐ Psoriasis ☐ Rosacea

☐ Precancerous (Dysplastic) Moles ☐ Lupus Other: _____

☐ **Melanoma Skin Cancer: When/Where** _____

Do you have a family history of Melanoma: YES/NO If yes, which relative? _____

Do you wear sunscreen? Yes/No. If yes, what SPF? _____ Tanning bed use? Yes/No. If yes, for how long? _____

Social History: (Circle One)

Smoking Status: Never Smoked Current Smoker Former Smoker: Total years smoking_____

Alcohol Intake: None 1 or less per day 1-2 per day 3 or more per day

Occupation: _____ (If retired, please list previous occupation)

If disabled, list disability): _____

Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

List any over the counter or herbal supplements you take:_____

Do you take any blood thinners? If so, please list: _____

Are you allergic to any medications? Yes/NO. If yes, list medications: _____

Do you have allergies to: ☐ Adhesive ☐ Lidocaine ☐ Topical Antibiotics

History of Staph infection or MRSA infection ☐ Yes ☐ No

Are you currently experiencing any of the following?

☐ Problems with bleeding	☐ Depression	☐ Bloody Urine	☐ Thyroid Problems
☐ Problems with Healing	☐ Joint Aches	☐ Sore Throat	☐ Muscle Weakness
☐ Problems with scarring	☐ Diarrhea	☐ Dry, Itchy Eyes	☐ Headaches
☐ Rash	☐ Nausea	☐ Blurry Vision	☐ Cough
☐ Immunosuppression	☐ Vomiting	☐ Night Sweats	☐ Seizures
☐ Fever/Chills	☐ Abdominal Pain	☐ Unintentional Weight Loss	

Signature of Patient: _____ Date: _____