BHS Dermatology
DERMATOLOGY ASSOCIATES

David A. Cowan, MD
Rebecca G. Pomerantz, MD
Lisa L. Ellis, PA-C
Sheri L. Rolewski, CRNP
Kelly Valasek, PA-C
Kendra Kekich, PA-C

WELCOME PACKET

We are pleased that you have chosen our practice for your dermatologic needs. Our goal is to provide the highest quality of care for your general, medical, and cosmetic dermatology needs.

Please complete this Welcome Packet 5 (five) days prior to your scheduled office visit and forward these forms to our office via mail or fax. If you are unable to return the Welcome Packet via mail or fax 5 (five) days prior to your appointment, please plan to bring completed packet the day of your appointment.

If you have been referred to our office by another doctor, please have your records sent to our office before your scheduled appointment. Your records can be faxed to our office at **724-482-2212**.

We accept most insurance plans and will be happy to help you determine if we participate with your insurance. If your insurance requires a referral, it is your responsibility to obtain that referral and confirm that our office has received your referral prior to your scheduled appointment.

Many insurance plans require that we obtain authorization for procedures performed in our office including biopsies, cryotherapy, and injections. We will do our best to minimize additional trips to our office, but you may be required to return to the office to have a procedure performed after your initial consultation.

For your appointment please bring:

1. **A list of your current Medications including Over the Counter Medications**
2. **Your Insurance Card**
3. **Your Photo Identification**
4. **Your Recent Lab or Pathology Results**

Our policies are as follows:

1. Your co-pay is due when you arrive for your scheduled appointment.
2. Your completed Welcome Packet is to arrive in our office 5 days prior to your scheduled appointment.
3. Cancellation policy: Please provide at least a 48 hour notice if you are not able to arrive at your scheduled appointment. We will reschedule your appointment promptly.
   * You may be charged a $25 cancellation fee if you fail to provide a 48 hour notice to our office.
4. If you arrive late for your scheduled appointment you may be asked to reschedule your appointment.

Please do not hesitate to call our office with any questions at **1-877-661-3376**

BHS Dermatology Associates

Benbrook Medical Center
102 Technology Drive Suite 230/240
Butler, PA 16001

300 NorthPointe Circle
Suite 104
Seven Fields, PA 16046

BHSdermatology.org

Phone: 1-877-661-3376 Fax: 724-482-2212

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HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

What is the reason for your visit today? _____

When did you notice it? _____ **Symptoms:** _____ **Referred by:** _____

Preferred Pharmacy Name: _____ ***Pharmacy Telephone:*** _____

Pharmacy Address/Location: _____ ***Pharmacy Fax:*** _____

MEDICAL HISTORY: Please check all that apply – Past or Present

SKIN CANCER: ☐None ☐**Malignant Melanoma** ☐**Basal Cell Carcinoma** ☐**Squamous Cell Carcinoma**

☐ Other Cancer(s) (Please List Types): _____

If **Skin Cancer:** When treated and at what Facility: _____

☐ Acne	☐ Arthritis	☐ Asthma	☐ Colon/Intestinal Disorder
☐ Bleeding, Excessive	☐ Blood Clots	☐ Bruising Easily	☐ Headaches (chronic)
☐ Diabetes	☐ Eczema	☐ Hay Fever	☐ Herpes Zoster (Shingles)
☐ Heart Problems	☐ Hepatitis	☐ Herpes Simplex (cold sores)	☐ Kidney Disease
☐ High Blood Pressure	☐ HIV/AIDS	☐ Infections (chronic)	☐ Lupus
☐ Liver Disease	☐ Loss of Skin Pigment	☐ Lung Disease	☐ Rheumatic Fever
☐ Mitral Valve Prolapse	☐ Pacemaker	☐ Psoriasis	☐ Thyroid Disease
☐ Scarring/Keloids	☐ Sexually Transmitted Disease	☐ Stroke	☐ Vitiligo
☐ Tuberculosis	☐ Ulcers, Skin	☐ Varicose Veins	
☐ Warts	☐ Wound healing difficulty	☐ OTHER (Please list): _____	

*** Females:** ☐Chronic vaginal infections ☐Taking oral contraceptives (list): _____
☐Currently pregnant ☐Possibly pregnant ☐Breast Feeding
☐Date of last menstrual period: _____ ☐Hysterectomy

SURGICAL HISTORY: **Type** of Surgery and **Date** of Surgery

1. _____ 2. _____

HISTORY OF RADIATION TREATMENT: ☐**No** ☐**Yes** _____

CURRENT MEDICATIONS: ***LIST MEDICATIONS BELOW AND PLEASE ALSO BRING MEDICATION LIST TO YOUR APPOINTMENT***
INCLUDE-Name of Medication-Strength (ie: 20mg-40 etc.) - Dose (Tablet-Capsule etc.) Frequency (1 a day etc)

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

DO YOU REQUIRE PRE-MEDICATION PRIOR TO SURGERY? ☐ **No** ☐ **Yes**

* Do you take **Antibiotics** prior to **Dental Procedures, Surgeries** or do you have a **Heart Valve** or **Artificial Joint**
(Describe)_____

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DRUG ALLERGIES: Please check and name the specific drug and if known list the type of reaction you experienced:

☐ No Known Drug Allergies ☐ Anesthetics_____ ☐ Aspirin_____
☐ Lidocaine _____ ☐ Penicillin_____ ☐ Sulfa _____
☐ Tetracycline_____ ☐Other drugs _____

TYPE OF REACTION: _____

ARE YOU ALLERGIC TO LATEX: ☐ **No** ☐ **Yes** Include Reaction _____

NON-DRUG ALLERGIES: Include Reaction _____

SOCIAL HISTORY:

Do you use **SUNSCREEN**? ☐ **Yes** ☐ **No** If so SPF?: _____ **Do you Tan in a Tanning Bed:** ☐**Yes** ☐**No**

Do you drink **ALCOHOL**? ☐ **Yes** ☐ **Never** ☐ **Quit** If yes, how much? _____How often? _____

Do you use **TOBACCO**? ☐ **Yes** ☐ **Never** ☐ **Quit** How much per day? ____ How many years? _____

Do you use **RECREATIONAL DRUGS**? ☐**Yes** ☐**Never** ☐ **Quit** If yes, how much? ____ How many years? ____

OCCUPATION: _____ ☐ **Working** ☐ **Retired** ☐ **Disabled**

☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Children: ☐ **Yes** ☐ **No** If yes, how many? _____

FAMILY HISTORY: (Please check all that apply and list family member)

☐ Allergies/Hay Fever_____ ☐ Arthritis _____ ☐ Asthma _____ ☐ Cancer_____
☐ Collagen Vascular Disorder_____ ☐ Diabetes_____ ☐ Eczema _____ ☐ Lupus_____
☐ Malignant Melanoma_____ ☐ Psoriasis _____ ☐ Skin Cancer _____ ☐ Tuberculosis_____

OTHER PERTINENT HISTORY: _____

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY and USE OF MEDICAL PHOTOGRAPHY

__ ***I hereby authorize BHS Dermatology Associates Staff to utilize medical photography in my care and consent to have photographs taken of the area(s) of the skin/body being examined and treated. Medical photography may include still photography as well as video photography, or other images. I understand that the photographs will only be used to aid in diagnosis and treatment plans, health care administration, and other uses specifically allowed by law. These photos will be kept on file in my medical record and I will have access to these photos upon written request. Images taken before, during, and after medical and surgical procedures may be included as part of my medical record. I understand that these photographs will not be printed, published, or otherwise circulated without further consent.***

__ ***I do not authorize photographs to be taken during my visit***

__ ***I hereby authorize BHS Dermatology Associates Staff to use the photographs within my medical record for purposes of medical education and teaching, for publication in medical textbooks and journals, and for marketing and advertising in print or on the BHS Dermatology Website. These photographs will not be sold at any time to a third party. My name will not be identified and every effort will be made to limit the ability of others to identify me in pictures. By giving consent to Dr. David A. Cowan and all representatives and staff of BHS Dermatology to use my medical photographs, I understand that I will not receive payment from any party at any time. I hereby release and discharge Dr. David A. Cowan, BHS Dermatology Associates, and their employees, trustees and offices from any claims, demands, or legal actions for use of these images from my medical record.***

__ ***I do not authorize the use of my photographs from my medical record for purposes of medical education and teaching***

Patient Signature: _____ Date/Time: _____

OR

Patient Representative: _____ Date/Time: _____

Provider Signature: _____ Date/Time: _____

BHS Dermatology Associates
Rebecca G. Pomerantz, MD
300 Northpointe Circle
Suite 104
Seven Fields, PA 16046

1. **Route 8- From Butler**

   South on Route 8 (Also known as Pittsburgh Rd.)
   Make a slight right onto Mars Rd/ PA 228
   Turn left onto Castle Creek Dr. Ext.
   Take the first left onto Northpointe Circle
   300 Northpointe Circle is the 2nd building on the right

2. **Route 8- Coming North**

   North on Route 8 (Also known as Pittsburgh Rd.)
   Make a slight left onto Mars Rd/PA 228
   Turn left onto Castle Creek Dr. Ext.
   Take the first left onto Northpointe Circle
   300 Northpointe Circle is the 2nd building on the right

3. **Route 79- Coming South**

   Take PA-228 E, Exit 78, towards Mars/Seven Fields
   Turn left onto PA-228 /Route 228
   Turn right onto Castle Creek Dr. Ext.
   Take the first left onto Northpointe Circle
   300 Northpointe Circle is the 2nd building on the right

4. **Route 79- Coming North**

   Take PA-228 E, Exit 78, towards Mars/Seven Fields
   Turn right onto PA-228 /Route 228
   Turn right onto Castle Creek Dr. Ext.
   Take the first left onto Northpointe Circle
   300 Northpointe Circle is the 2nd building on the right