

David A. Cowan, MD
Lisa L. Ellis, PA-C
Kelly Valasek, PA-C

Rebecca G. Pomerantz, MD
Sheri L. Rolewski, CRNP
Kendra Kekich, PA-C

WELCOME PACKET

Page 1 of 1

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 Page 1 of 2

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

What is the reason for your visit today? _____

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

Primary Care Physician: _____ **Referred by:** _____

Preferred Pharmacy Name: _____ **Pharmacy Address/Location:** _____

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: _____

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Colon/Intestinal Disorder |
| <input type="checkbox"/> Bleeding, Excessive | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Headaches (chronic) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Herpes Zoster (Shingles) |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes Simplex (cold sores) | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Infections (chronic) | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Loss of Skin Pigment | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Scarring/Keloids | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vitiligo |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers, Skin | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Wound healing difficulty | <input type="checkbox"/> 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 David A. Cowan, MD Suite 230
BHS Center for Dermatology Surgery David A. Cowan, MD Suite 240
Benbrook Medical Center 1 102 Technology Drive Butler, Pa 16001

*** 422 Westbound – From Kittanning**

Pass Route 356 Lyndora/Butler Exit
Turn Left on Greenwood Drive .5 Miles
Bottom of the Hill - Right onto Benbrook Road (NOT Marked) 1.0 Miles
Right onto Technology Drive .2 Miles

Benbrook Medical Center 1

1st 2 story Building on your Right

BHS Dermatology Associates – David A. Cowan, MD

Second Floor – Suite 230 / Suite 240

***422 Eastbound – From New Castle**

Turn Right onto Greenwood Drive .5 Miles
Bottom of the Hill - Right onto Benbrook Road (NOT Marked) 1.0 Miles
Right onto Technology Drive .2 Miles

Benbrook Medical Center 1

1st 2 story Building on your Right

BHS Dermatology Associates – David A. Cowan, MD

Second Floor – Suite 230 / Suite 240

***Arriving from Slippery Rock from Route 8**

PA 8

Right onto South Benbrook Road 4.2 Miles

Right onto Technology Drive .2 Miles

Benbrook Medical Center 1

1st 2 story Building on your Right

BHS Dermatology Associates – David A. Cowan, MD

Second Floor – Suite 230 / Suite 240

***Arriving from Evans City / 79 / PA 68**

PA Route 68

Left onto Benbrook Road .2 Miles

Left onto Technology Drive .2 Miles

Benbrook Medical Center 1

1st 2 story Building on your Right

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Second Floor – Suite 230 / Suite 240