DERMATOLOGY & SKIN SURGERY

NOTE: This document works best in Overtype mode. Press the Insert key to change mode.

Patient Name: __Mr./__Mrs./__Ms. _____ Age: _____
Last First M.I.

Date of Birth: _____/_____/_____ Sex: __M __F Email Address: _____

S.S. # _____/_____/_____ Marital Status: __S __M __D __W Other:_____

Race: __White __Hispanic __African American __American Indian __Asian __Other:_____

Ethnicity: __Hispanic __Non-Hispanic Other:_____

Address: _____
Street City State Zip

Telephone Number :(_____)_____ Alternate Telephone Number : (_____)_____

Employer:_____ Phone:(_____)_____

Responsible Party (who pays bill): __Self __Other: _____ Relationship: _____

INSURANCE SUBSCRIBER INFORMATION:

Policy Holder Name: _____ Date of Birth: _____/_____/_____

Relationship: _____ S.S # _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone: (_____)_____

Primary Physician: _____ Telephone: (_____)_____

Primary Physician Address: _____

Pharmacy Name: _____ Pharmacy Phone #: (___)_____

Pharmacy Address/Location: _____ Pharmacy Fax #: (_____)_____

DERMATOLOGY & SKIN SURGERY

Patient Consent for Use and Disclosure of Protected Health Information/ Consent to Treat

I give permission to Dermatology & Skin Surgery to leave messages regarding my medical care, including lab results at: __phone __email __both (place an X before the preferred method)

_____

I give permission to Dermatology & Skin Surgery to discuss my medical care with:

Permission to speak with:_____ Relationship:_____

I authorize Dermatology & Skin Surgery to contact me by mail. __Yes __No

I authorize Dermatology & Skin Surgery to release any information acquired in the course of my exam or treatment to my insurance company, primary care physician, or another physician. I authorize Dermatology & Skin Surgery to take medical photographs of myself as part of my medical record. I agree that Dermatology & Skin Surgery may access my medication history from other healthcare providers and/or pharmacies for treatment purposes.

I acknowledge that I have been given the Dermatology & Skin Surgery Notice of Privacy Practices.

I consent to surgical, medical, and/or diagnostic treatment by the staff of Dermatology & Skin Surgery as deemed necessary to treat my condition(s).

_____ _____

Patient Signature (or responsible party) Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Payment is due at time service is provided.

I understand that I am financially responsible for all services not paid for by my insurance company; including co-payments, deductible amounts, or services that are not a covered benefit by my plan.
I hereby assign all medical and/or surgical benefits to Dermatology & Skin Surgery. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

NO-SHOW POLICY

Any appointment not cancelled or rescheduled 24 hours prior is subject to a $50 service fee.

REFERRALS

If your insurance requires a referral from your primary physician, this referral must be in place before your appointment. If you arrive without the referral required by your insurance company, you may be seen as a non-insured/cash patient or reschedule to allow time for you to obtain the needed referral.

LABS

If your insurance carrier requires the use of a specific laboratory, the staff must be informed before the specimen is taken.

MEDICARE PATIENTS

I authorize release of my medical information to Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Dermatology & Skin Surgery. I permit a copy of this authorization to be used in place of the original.

I have read, understand, and agree to this financial policy.

_____ _____

Patient Signature (or responsible party) Date

DERMATOLOGY & SKIN SURGERY

Patient: _____ **DOB** _____**Date**:_____

Reason for today's visit: _____

Medication Allergies: _____

Are you allergic to local anesthesia like Novocaine or Lidocaine? Yes No
Do you develop skin rashes in reaction to:
□ Bandages/adhesives □ Latex □ Neosporin/Polysporin □ Other _____

Do you take aspirin or blood thinners? Yes No **Smoke?** Yes No **Drink alcohol?** Yes No

HEIGHT: _____ft _____in **WEIGHT:** _____ lbs

List medications you currently take (include prescriptions, over-the-counter, vitamins, herbs & supplements):

_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICAL HISTORY
List any diseases or conditions:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Surgeries: _____

Pregnant: Yes No Due Date: _____
Breastfeeding: Yes No

SKIN CANCER HISTORY:

□ Melanoma □ Basal Cell Carcinoma □ Squamous cell carcinoma □ Other_____

Location of the skin cancer and date treated: _____

Have you been told to take oral antibiotics before dental or other procedures? Yes No

Do you develop keloids (raised bumpy scars)? Yes No

FAMILY HISTORY OF MELANOMA: Yes No If yes, which relative:_____

What is your occupation? _____

How did you hear about us? _____

Provider Signature:_____ Date: _____

Gina G. Harney, MD Julie Darby-Jett, MPAS, PA-C