DERMATOLOGY & SKIN SURGERY

Patient Name: Mr./Mrs./Ms./Miss_____ **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

Primary Cell Number :( )_____ **Alternate Home 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 #:** (____)_____

How did you hear about our office? _____

Patient or Parent/Guardian Signature: _____ **Date:** _____

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 (please circle)

_____

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 (please circle)

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 Revised 2/2018

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 (Please circle all that apply):
Bandages/adhesives Latex Neosporin/Polysporin environment, other _____

Do you take aspirin or blood thinners? Yes No **Do you smoke?** Yes No **Do you drink alcohol?** Yes No

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

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

FAMILY HISTORY (Please circle all that apply)

Skin Cancer: Basal cell carcinoma Squamous cell carcinoma Melanoma Other:_____
Psoriasis Hayfever Arthritis Diabetes Asthma Cancer Eczema Multiple Sclerosis
OTHER: _____

PAST MEDICAL HISTORY (Please circle all that apply to you personally)

General Health: Excellent / Good / Poor
Multiple Sclerosis / Fibromyalgia / Chronic Fatigue
Eczema / Psoriasis, _____
Ear / nose / throat / or mouth disease
Stroke / TIA's / Seizures / Headaches
Diabetes / Thyroid disease
Heart disease / Heart attack
Mitral valve prolapse / Heart murmur
Pacemaker / Defibrillator
Heart valve replacement
Asthma / Tuberculosis
Allergies / Hay fever
Lupus / Rheumatoid arthritis / Other_____
Artificial joint replacement _____
Herpes / Cold Sores / Keloids / Hives
Organ transplantation _____
Menstrual irregularities _____
Pregnant: No Yes Due Date: _____
Depression / BiPolar / Anxiety _____
Cancer type_____
Radiation therapy / Chemotherapy
Bleeding disorder / Anemia
Hepatitis/ AIDS / HIV positive
High Blood Pressure (Hypertension)

List any other diseases or conditions: _____

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

Past Surgeries: _____

SKIN CANCER HISTORY: (Please circle all that apply)

○ Melanoma ○ Basal Cell Carcinoma ○ Squamous cell carcinoma ○ other_____

Location of the skin cancer and date treated: _____

When exposed to the sunlight, do you ○ Burn ○ Burn-then tan ○ Tan

Do you use sunscreen ○ Daily ○ Seldom ○ Never ○ only when I am outside sports/fun/etc.

Do you have problems with healing? (Please explain)_____

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

What is your occupation? _____ **Hobbies**: _____

How did you hear about us? _____

Physician Assistant Signature:_____ Date: _____
Julie Darby-Jett, MPAS, PA-C

Physician's Signature:_____ Date: _____
Gina G. Harney, MD

Revised 2/2018