

DERMATOLOGY & SKIN SURGERY

Patient Name: Mr./Mrs./Ms. _____ **Age:** _____
Last First M.I.

Date of Birth: ____/____/____ **Sex:** M F **Email Address:** _____

Address: _____
Street City State Zip

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

Responsible Party (who pays bill): Self Other: _____ **Relationship:** _____

INSURANCE SUBSCRIBER INFORMATION:

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

EMERGENCY CONTACT

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Telephone: (_____)_____

Primary Physician: _____ **Telephone:** (_____)_____

Pharmacy Name & Location: _____ **Pharmacy telephone:** (_____)_____

S.S. # ____/____/____

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:

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

_____ Relationship: _____

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

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

DERMATOLOGY & SKIN SURGERY

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

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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 Hay fever Arthritis Diabetes Asthma Cancer Eczema

Multiple Sclerosis OTHER: _____

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

General Health: Excellent/ Good/ Poor

Lupus/ Rheumatoid arthritis/ Other _____

Multiple Sclerosis/ Fibromyalgia/ Chronic Fatigue

Artificial joint replacement _____

Eczema/ Psoriasis, _____

Herpes/ Cold Sores/ Keloids/ Hives

Ear/ nose/ throat/ or mouth disease

Organ transplantation _____

Stroke/ TIA's/ Seizures/ Headaches

Menstrual irregularities _____

Diabetes/ Thyroid disease

Pregnant Yes No Due Date: _____

Heart disease/ Heart attack

Depression/ BiPolar/ Anxiety _____

Mitral valve prolapse/ Heart murmur

Cancer type _____

Pacemaker/ Defibrillator

Radiation therapy/ Chemotherapy

Heart valve replacement

Bleeding disorder/ Anemia

Asthma/ Tuberculosis

Hepatitis/ AIDS/ HIV positive

Allergies/ Hay fever

High Blood Pressure

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 Dermatology and Skin Surgery? _____

Physician's Signature: _____ Date: _____

Gina G. Harney, MD

Date: _____

Linda Hua, MPAS, PA-C