Dermatology Specialists

Medical History

Patient Name: _____Date of Birth: ____/____/___ Today's Date: __/__/__/____

Reason for today's visit: _____

Description and duration of symptoms: _____

Was a biopsy performed? ☐Yes ☐ No If yes, when? _____ Who performed the biopsy? _____

List any previous treatments for this condition: _____

List all medication allergies:_____

Have you ever had a bad reaction to local anesthesia (Novocaine, Lidocaine, etc)? ☐ Yes ☐ No

Have you had bad reactions to: ☐ bandages ☐topical antibiotics ☐ foods _____ ☐environment _____

List all medications you currently take (including over-the-counter meds, aspirin, vitamins, herbals and prescriptions):
1. _____ 3. _____ 5. _____ 7._____
2. _____ 4. _____ 6. _____ 8._____

Have you previously had skin cancer? ☐ Yes ☐ No If yes, what type? _____

Please list **date** and **location** (on your body) of the cancer(s), **how** they were treated and **by whom**:
_____

Do you have now, or have you ever had diseases or conditions of: (Please check Yes or No)

Skin:	**YES**	**NO**
Abnormal bleeding	☐	☐
Keloids (abnormal scarring)	☐	☐
Poor healing	☐	☐
Family history of melanoma	☐	☐
History of blistering sunburns	☐	☐
Cardiovascular:		
High blood pressure	☐	☐
Irregular heart beat	☐	☐
Chest pain	☐	☐
Heart murmur	☐	☐
Atrial fibrillation	☐	☐
Artificial heart valve	☐	☐
Heart attack	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐

Infections:	**YES**	**NO**
Cold sores/fever blisters/herpes	☐	☐
Hepatitis	☐	☐
HIV/AIDS	☐	☐
Immunosuppression	☐	☐
Other systemic:		
Arthritis	☐	☐
Artificial joint	☐	☐
If yes, which and how long ago? _____		
Diabetes	☐	☐
Thyroid disease	☐	☐
Kidney disease	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List any surgeries you have had: _____

Do you smoke? ☐Yes ☐No Do you use IV drugs? ☐ Yes ☐ No Have you ever used a tanning bed? ☐ Yes ☐ No

Do you drink alcohol? ☐Yes ☐ No If yes, how much? _____ Did you receive the flu vaccine this year: ☐Yes ☐No

Have you ever had a pneumonia vaccine? ☐Yes ☐No Do you have a history of Melanoma? ☐Yes ☐No

Do you have Psoriasis? ☐Yes ☐No Have you provided us with an updated medication list? ☐Yes ☐No

Is this your first visit to this practice? ☐Yes ☐No What is your height? ___ft___in Weight? _____lbs

Are you pregnant? ☐Yes ☐No Breastfeeding? ☐ Yes ☐No Trying to conceive? ☐ Yes ☐ No

What is your occupation? _____ Hobbies: _____

Are you interested in learning more about our cosmetic services? ☐Yes ☐No

Completed by: ☐ Patient **X**_____ Date____/_____/_____
Signed by patient/representative

☐ _____ _____ Date____/_____/_____
Reviewed by

Dermatology Specialists

REGISTRATION SHEET – PLEASE COMPLETE

Last name _____
First name_____MI___
(As printed on Insurance card if applicable)
Date of birth_____

Primary Care Physician _____
Telephone # of PCP_____
Referring Provider_____

Sex: M or F
Address line 1_____
Address line 2_____
City_____
State _____ Zip_____
Home phone_____
Cell phone_____
Work phone_____
Preferred pharmacy name & location:
_____
Email address_____
(for DS purposes only will not be shared)

Marital status: S/ M/ W/ Partner
Social Security #_____
Employer name_____
Race/Ethnicity _____
Preferred Language _____
How did you hear about us?
Other Patient _____ Referral _____ Ad_____
Emergency contact_____
Phone #: _____
Relationship to Patient:_____

Primary Insured Responsible Party (Fill out this portion if different from Self)

Name: Self / Other Named _____MI: _____ DOB_____
Address:_____City_____State_____Zip_____
Telephone #:_____Relationship to Pt_____
Subscriber # _____ Group #:_____

INSURED RESPONSIBILITY: It is understood that services rendered by DS are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of DS to collect from the insurance company. We do this as a service to our patients.

PATIENTS: I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to promptly pay the balance in full.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All returned checks (NSF, Account Closed, Refer to Maker, or Uncollected Funds) are subject to a $40 service charge and cost of collection fee. In consideration of any services rendered by DS, or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for DS to employ anyone, including collection agencies and attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a $25 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to DS.

Do we have your permission to:
1) Is it ok to leave a detailed message? Yes ___ No ___ Preferred # Home _____ Cell_____
2) Discuss your medical condition with any member of your family? If yes Whom? _____Relationship:_____
Whom? _____Relationship:_____

In signing this document, I am attesting that I have read the above and that I have had all of my questions answered to my satisfaction.

_____ _____
PATIENT SIGNATURE/LEGAL GUARDIAN DATE

Dermatology Specialists

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Insurance Authorization And Assignment, I hereby authorize Dermatology Specialists to furnish information to insurance carriers concerning my diagnosis and treatments and I hereby assign to the physicians all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance and all collections costs should this account be assigned for collection. I accept and understand the responsibility of notifying DS of any requirement by my insurance company of pre-authorization prior to any surgical procedure. I understand that if I fail to get a referral, if necessary, I will be responsible for the charges.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

FOR OFFICE USE ONLY

This consent was signed in front of _____

Dermatology Specialists
Financial Policy

Thank you for choosing Dermatology Specialists! Our practice firmly believes that a good physician/patient relationship is based upon good understanding and clear communication. We are committed to the success of your medical care and well-being. Please understand that payment for your financial responsibility is necessary for us to be able to continue to serve you and our community. To help avoid misunderstandings, our financial policy is in writing below.

Patients/guarantors are responsible for understanding their insurance benefits. We may be able to help explain your insurance but it is always best for you to speak with them directly as we do not have your plan agreement available to us. For example, many procedures performed in our office may apply towards your deductible or co-insurance. These are expenses that are beyond your specialist copay. You will need to know what your insurance responsibility may be.

All biopsies and mole removals performed in our office may be submitted for pathology for analysis. Some of the tissue may be processed in our in-office lab or sent to an outside pathology lab. Please note that depending on your benefits, you might receive a separate bill for pathology. **Tests and treatments performed in our office are necessary to ensure proper diagnosis and care for our patients.** Below are some examples of procedures (classified as surgery by most insurance companies) that could be applied towards deductibles and co-insurance:

- Biopsies and lesion removals. This includes all excisions for skin cancer and atypical moles or benign lesions.
- Liquid nitrogen for the destruction of lesions (warts and pre-cancerous lesions)
- Injections
- Photodynamic Therapy (PDT)

All copays and outstanding balances are due at the time of service unless other arrangements have been made in advance

Our practice accepts cash, checks, money orders, Visa, MasterCard, Discover and American Express as forms of payment.

I have read and understand the Financial Policy for Dermatology Specialists. I agree if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charges by the collection agency for the cost of collections.

Patient/Guardian Signature: _____ Date: _____

Printed Patient Name/Guardian: _____ DOB: _____