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_____________________________

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)

Sex: M or F
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 goal is to provide you with the highest level of patient care. We believe that communication between our practice and our patients, on all levels, is very important. For this reason, we would like to outline some of the specifics of our financial policy.

Co-pays are due at the time of your office visit

****Any outstanding insurance deductibles are due at the time of your surgery/procedure****

*****If a referral is required by your insurance company, please contact your primary care physician to ensure our office receives a copy prior to your scheduled appointment*****

Patient insurance cards and current billing information will be required for our office to file a claim with your insurance company on your behalf. If this information is not provided at the time of your visit, we will require immediate payment in full for services received. Payment in full is also expected for self-pay medical patients as well as for cosmetic services and treatments.

"IN-NETWORK" CONTRACTED INSURANCE CARRIERS: As a service to you, we will file your health insurance claims with our contracted companies. Once your insurance claim is processed, your insurance company will determine your remaining financial responsibility due to Dermatology Specialists and notify you through an explanation of benefits.

"OUT-OF-NETWORK" NON-CONTRACTED COMMERCIAL INSURANCE CARRIERS: As a service to you, we will file all claims on your behalf. Please be aware that your financial responsibility may increase due to "out of network" benefits. Co-pays and deductible amounts will apply.

MEDICARE: As a service to you, we will file Medicare claims on your behalf. If you carry supplemental insurance, please provide us with that information at the time of your visit. Please note that secondary insurance billing is most efficient if you are enrolled in the Medicare Crossover plan, which you must do yourself.

MEDICAID: Please be aware Dermatology Specialists is not a Medicaid provider.

TRAVEL INSURANCE:
Payment will be required at the time of service. Dermatology Specialists will provide an insurance claim form which you can submit for reimbursement through your insurance company.

While we file insurance claims as a courtesy to you, it remains your responsibility to contact and confirm your coverage benefits. Patient or responsible party acknowledges that delinquent accounts will be subject to the services and fees of a collection agency. Returned checks will be assessed a fee of $40.

Patient	Responsible Party	Relationship to Patient

Signature of Patient or Responsible Party	Date