DERMDOX
Dermatology Centers

# PATIENT INFORMATION

Today's Date: _____/_____/_____

◯Mr. ◯Mrs. ◯Miss. ◯Ms. Marital Status: ☐ Single ☐Married ☐Divorced ☐ Separated ☐Widowed

Name: _____ Date of Birth: ____/_____/_____ AGE: ____ SEX: _____
First Last M.I.

Address: _____
Street City ST Zip

Cell Phone: _____-_____-_____ Home: _____-_____-_____ Email: _____

Where did you hear about us? ☐ Advertising ☐ Word of mouth ☐ Web search ☐ Other

Who referred you to our office? _____

Primary Care Physician: _____Location: _____Phone: _____-_____-_____

Preferred Pharmacy: _____ Location: _____ Phone:_____-_____-_____

Do you have an Advanced Care Plan? Meaning, you have someone to make any medical decision for you if for any reason you are unable to.

**Patient IS their own POA (Power of Attorney)** ☐ Yes ☐ No

If no, Name of POA: _____ Phone: _____-_____-_____

# INSURANCE INFORMATION

Primary Insurance: _____ Subscriber ID #: _____ Spec Co-pay $_____
Primary Card Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Secondary Insurance: _____ Subscriber ID #: _____
Primary Card Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

# EMERGENCY CONTACT

Name: _____ Relationship to patient: _____ Phone:_____-_____-_____

The above informatin is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DermDox Dermatology Centers or insurance company to release any information required to process any claim(s).

Patient/Guardian Signature: _____ Date: _____/_____/_____

# MEDICAL HISTORY

## Past/Present Medical History (Please check ☑ all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Hypotension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Immunosuppressant
- ☐ MRSA
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None of the Above
- ☐ Other: _____

## Past Surgical History (Please check ☑ all that apply)

- ☐ Basal Cell Cancer Surgery
- ☐ Joint Replacement; Hip (Right, Left, Bilateral) within past two years
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Mechanical Heart Valve Replacement
- ☐ Melanoma Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ None of the Above
- ☐ Other: _____

## Skin Disease History (Please check ☑ all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None of the Above
- ☐ Other: _____

| | YES | NO | |
|---|---|---|---|
| Do you wear sunscreen? | ☐ | ☐ | If yes, what SPF? _____ |
| Do you tan in a tanning salon? | ☐ | ☐ | |
| Do you have a family history of Melanoma | ☐ | ☐ | If yes, which relative(s)?_____ |

**Medications**
(Please list all current medications)

_____
_____
_____
_____
_____
_____
_____

**Allergies**
(Please list all allergies)

_____
_____
_____
_____
_____
_____
_____

☐ **See attached list**

## Social History

**Cigarette Smoking**
- ☐ Never Smoked
- ☐ Quit: Former Smoker
- ☐ Smoke less than daily
- ☐ Smoke daily

**Vaccine**
- ☐ FLU — When? _____/_____ Mo/Yr
- ☐ Pneumonia — When? _____/_____ Mo/Yr

**Alcohol Use**
- ☐ Yes
- ☐ No

**Last Menstrual Period: _____/_____/_____** ☐ N/A

## Reason for visit:

_____
_____
_____

**Please check ☑ if you have any of the following:**

| | | | |
|---|---|---|---|
| Allergy to Adhesive | ☐ | Blood Thinners | ☐ |
| Allergy to Latex | ☐ | Defibrillator | ☐ |
| Allergy to Lidocaine | ☐ | Premedication prior to procedure | ☐ |
| Allergy to topical antibiotic cream | ☐ | Problems with bleeding | ☐ |
| Pregnant or planning a pregnancy | ☐ | Rapid Heartbeat with Epinephrine | ☐ |
| Breast Feeding | ☐ | West Africa Contact or Travel | ☐ |

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# Health Insurance Portability and Accountability Act (HIPPA)
# Ley de Responsabilidad y Portabilidad del Seguro de Salud

Name: _____ Date of Birth: _____/_____/_____

| | Yes | No |
|---|---|---|
| May we leave medical information for you on your cell/home phone and/or answering machine? | ☐ | ☐ |
| Appointment reminders via text message | ☐ | ☐ |
| Emails on appointment reminders/specials/promotions | ☐ | ☐ |
| May we send medical information through mail? | ☐ | ☐ |

With whom we share privacy information regarding your care? Please list name(s) and contact information.

Name: _____ Relationship: _____ Phone: _____-_____-_____

Name: _____ Relationship: _____ Phone: _____-_____-_____

Name: _____ Relationship: _____ Phone: _____-_____-_____

Patient/Guardian Signature: _____ Date: _____/_____/_____

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# PAYMENT POLICY

Thank you for choosing us as your dermatologist. We are committed to providing you with a quality and affordable healthcare. We understand you may have some questions regarding patient and insurance responsibility for services renderedand hope that we can provide more understanding on this topic.

**INSURANCE** We participate in most plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card(s), payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**CO-PAYMENTS AND DEDUCTIBLES** All co-payments and deductibles must be paid for at the time of service. This arrangement is part of your contract with your insurance company.

**NON-COVERED SERVICES** Please be aware that some, and perhaps all, of the services you may receive may be non-covered or not considered medically necessary by your insurance company. You must pay for these services in full at the time of your visit.

**PROOF OF INSURANCE** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be reponsible for the balance of a claim.

**CLAIMS SUBMISSION** We will submit our claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. Its is your responsibility to comply with their requests. The balance becomes your responsibility if no payment is received from your insurance.

**COVERAGE CHANGES** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

**NO SHOWS** Our policy is to charge **$50.00** (medical) or **$150** (surgical) for no shows/missed appointments that are not cancelled within 24 hours prior to your scheduled appoinment. These charges will be your responsibility and billed directly to you. Of course we understand unexpected emergencies can happen and we are understanding of these situations. Please help us to serve you better by keeping your regularly scheduled appointment. Laser deposits are refundable (5) days prior to your appointment. Any cancellation thereafter forfeits your deposit.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for your understanding of our office policies. Please let us know if you have any questions. or concerns.

I have read and understand the office policies of DermDox Dermatology Centers and agree to abide by it guidelines.

Signature _____ Date: _____/_____/_____

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# Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____ Date of Birth: _____/_____/_____

I have received and/or reviewed this practice's ***Notice of Privacy Practices.*** This notice provides details about the uses and disclosure of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with resect to my information.

I understand that this practice reserves the rights to change the terms of its ***Notice of Privacy Practices,*** and to make any changes regarding all protected health informatioin residing in or controlled by this practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

Signature _____ Date: _____/_____/_____

Relationship to patient (If signed by a personal respresentative of the patient) _____