Patient Information Sheet

Please fill out the entire form. If a question does not pertain to you, please write N/A (non-applicable).

Last Name: _____ First Name: _____

D.O.B: _____ Sex: Male / Female SS#: _____ Marital Status: M S D W

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Alternate Address: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Work #: _____

Primary Care Doctor: _____ City, State: _____

Which doctor referred you here? _____ City, State: _____

Pharmacy _____ City and Cross Streets _____ Pharmacy Phone # _____

Where did you hear about us? ☐ Tv ☐ Internet ☐ Paper ☐ Family/Friend ☐ Insurance Other: _____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

Race: _____	Ethnicity: _____
___American Indian/Alaska Native ___Nat. Hawaiian/Pacific Islander	___Declined
___Asian ___Other Race _____	___Hispanic or Latino
___Black/African American ___White	___Not Hispanic or Latino
___Declined	

Primary Language: _____

Do you understand English? Yes / No

Do you need ccommunication/translation assistance? Yes / No

INSURANCE INFORMATION

Insurance company: _____ Policy #: _____

Policy Holder Name: _____ Relationship to subscriber: _____

DOB: _____ Phone #: _____

Subscribers Address: _____ City, State, Zip: _____

Secondary Insurance: _____ Policy # _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Subscribers Address: _____ City, State, Zip: _____

Is this a work-related injury? Yes / No Is this related to an auto accident? Yes / No

Patient Name: _____ Date: _____

PREMIER Dermatology PARTNERS

History & Intake Form

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hypothyroidism
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

None Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement with last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

None Other: _____

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratoses
Asthma
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 Other: _____

Do you consume alcohol? Yes No

Are you a smoker? Yes No Former

Do you wear Sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No If yes, which relative(s)?

Medications: (Please enter all current medications) (Circle none if the answer is no) **NONE**

Allergies: (Please enter all allergies) (Circle none if the answer is no) **NONE**

Family History: (only first-degree relatives)

Diabetes? Yes/No if yes, which relative(s) (Circle none if the answer is no) **NONE**

Review of Systems:

Are you currently experiencing any of the following? (Please check yes or no for the following)

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Problems with bleeding			Cough			Diabetes		
Rash			Joint Aches			Hypertension		
Immunosuppression			Headaches			HIV/AIDS		
Chest Pain			Seizures			Hepatitis		
Fever or Chills			Shortness of breath			Nausea/Vomiting		
Thyroid Problems			Wheezing			New Skin Lesion(s)		
Sore Throat			Anxiety			Changes in Mole(s)		
Blurry Vision			Depression			Itching		
Abdominal Pain			Pacemaker			History of Skin Cancer		
Bloody Urine			Sinus problems					

Other Symptoms: _____

Alerts: (Please circle all that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?

NONE

Signature_____ **Date**_____

Patient Financial Policy

Thank you for choosing us for your healthcare needs. As your physician, we are committed to providing you with the best possible care. Please read our financial policy and, if you have any questions, please ask one of our associates for assistance or call our office at (844) 733-1400

PATIENTS WITH INSURANCE POLICIES

For insurance companies that we participate with:

We are pleased to bill your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at the time of service. In addition, you will be responsible for any amount the insurance plan deems not covered, up to the entire amount.

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues.

For insurance companies that we DO NOT participate with:

If your insurance has an out of network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. Phynet reserves the right to collect any unmet deductible or coinsurance at the time of service. It is ultimately the patient's responsibility to verify if we are in network and what the out-of-pocket costs in using an out-of-network provider will be.

SELF PAY PATIENTS

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required prior to the service. For your convenience, we accept cash, check, Visa, Mastercard, discover, and American Express. A returned check fee of $35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card.

COPAYMENTS

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are not prepared to pay your co-pay, your appointment will be rescheduled.

COINSURANCE

Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example, you may have an 80/20 plan, meaning the insurance will consider and pay 80% of the charges and the remaining 20% is your responsibility. It is very important to review your coverage to determine your level of coinsurance.

NO SHOW FEES

Patients who failed to keep appointments or cancel without 24 hours advance notice may be charged a $50 fee for an office visit, a $100 fee for a missed surgery/ASC appointment and a $75 fee for a cosmetic appointment.

PAST DUE ACCOUNTS

In the event a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fees associated with collecting the outstanding balance.

DISABILITY AND OTHER SPECIAL FORMS

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete these forms at the following rates:

- FMLA-$25
- Disability/Physician Attestation-$25
- Miscellaneous Forms-$25
- Medical Records-$35

Payment of the form filing fee is due at the time of request and a medical release form must be signed.

We will gladly discuss your proposed treatment and will do our best to answer any questions relative to your insurance. You must realize that: A) your insurance is a contract between you, your employer, and the insurance company. B) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As your medical provider, our relationship and concern is with you and your health, not your insurance company. While the filing of the insurance claims is a courtesy, all charges are your responsibility from the date services are rendered.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY. **Date:** _____

SIGNATURE: _____ **PATIENTNAME:** _____

Damage Disclaimer

Premier Dermatology Partners cannot be held responsible for personal property brought or worn by the patient onsite that is lost, stolen, or damaged while the patient is on the premises or parking areas for the premises.

All patients are encouraged to exercise proper care in securing all belongings or protecting belongings from damage.

I have read the above and understand my responsibility.

Health Insurance Portability and Accountability Act (HIPAA)

To our patients,

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment.

A means of communication among the many healthcare professionals who contribute to my care

A source of information for applying my diagnosis and surgical information to my bill.

A means by which a third-party payer can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

To object to the use of my health information for directory purposes.

To request restrictions as to how health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.

To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

In general, the **HIPPA** privacy rule gives individuals the right to request a restriction on uses and of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address. The physicians and staff of Premier Dermatology Partners respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

___I wish to be contacted by the telephone, fax, and email I provide, and it is OK to leave a detailed message on these. I also wish to permit Premier Dermatology Partners to contact my listed emergency contacts in the same way.

___I wish to be contacted by telephone only. However, any voicemail may only have a message identifying Premier Dermatology Partners calling and I do not wish any medical information to be left on voicemail.

___I give permission for photos to be taken of my skin. I understand that these photos will become part of my medical chart.

Other_____

PERSONAL RELEASE OF RECORDS

I authorize and request that my medical information may be released to the below Individuals.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Name _____ **Date of Birth**_____

Patient or Responsible Party Signature _____ **Date** _____