Date ___/___/___

Name: ____ Date of Birth: ___/___/___AGE: ______

Last **First** **MI**

Home Address: ____City: ______________________

State: ________________ Zip: ___________

2nd Home Address: ____ City: ______________________

State: ________________ Zip: ___________

Email Address: _____________________________ Home Phone: (___) ____________________

Work Phone: (___) ____________________ Cell Phone: (___) _________________________

Is it okay to leave messages containing your health information? Yes/ No

Preferred language: English/ Spanish/ Other: ________________

Ethnicity: Hispanic/ Non-Hispanic/ Unknown

Race: American Indian or Alaskan Native/ Asian/ Black or African American/ White

How were you referred? ______________________________________

Gender: Male – Female – Other **Marital Status:** Single – Married - Widowed – Divorced

Height: ____________ **Weight:** _____________

Emergency Contact: ________________________________ Phone: (___) ________________

Spouse/ Parent: ____________________________________ Phone: (___) ________________

Pharmacy Name: __________________________________ Phone: (___) ________________

Pharmacy Address: ____

Financial Responsible Party: Self/ Spouse/ Other

Name: Spouse/Other: ______________________________________ **Date of Birth:** ____/___/___

Primary Care Doctor: ___________________________

Past Medical History: (please check **Yes** or **No** for the following)

	Yes	**No**			**Yes**	**No**
Alzheimer's/ Dementia				Hepatitis		
Anxiety				Hypertension		
Artificial Joints				HIV/AIDS		
Asthma				Hypercholesterolemia		
Atrial Fibrillation				Hypothyroidism		
BPH				Leukemia		
Bone Marrow Transplant				Lung Cancer		
Breast Cancer				Lymphoma		
COPD				Pacemaker		
Depression				Prostate Cancer		
End Stage Renal Disease				Radiation Treatment		
GERD				Stroke/ TIA		
Hearing Loss				Valve Replacement		

Past Surgical History: (please check **Yes** or **No** for the following)

	Yes	**No**			**Yes**	**No**
Appendix Removed				Joint Replacement with in last 2 yrs.		
Bladder Removed				Kidney Biopsy		
Mastectomy (Right / Left / Bilateral)				Kidney Removed (right / left)		
Lumpectomy (Right / Left / Bilateral)				Ovaries Removed (Endometriosis/ Cyst/ Cancer)		
Breast Reduction				Kidney Transplant		
Breast Implants				Prostate Removed (Cancer)		
Colectomy: (Cancer / Diverticulitis / IBD)				Prostate Biopsy		
Gallbladder Removed				TURP		
PTCA				Skin Biopsy		
Mechanical Valve Replacement				Squamous Cell Carcinoma Surgery		
Biological Valve Replacement				Basal Cell Carcinoma Surgery		
Heart Transplant				Melanoma Surgery		
Knee Replacement (right / left)				Tonsils Removed (Right/ Left/ Bilateral)		
Hip Replacement (right, left)				Hysterectomy (Fibroids/ Uterine Cancer)		

Other: ____

<u>Skin Disease History</u>: (Please circle all that apply)

Acne

Actinic Keratosis

Basal Cell Skin Cancer

Blistering Sunburns

Dry Skin

Eczema

Hay Fever/ Allergies

Melanoma

Precancerous Moles

Poison Ivy

Squamous Cell Skin Cancer

Psoriasis

Flaking or Itching Scalp

<u>Other</u>: ____

Do you wear sunscreen? Yes No **Do you tan in a tanning salon?** Yes No

If yes, what SPF? _____________

Do you have family history of Melanoma? Yes No

If yes, which relative (s)? ____________________________________

Any other family history: ___________________________________

<u>Medications</u>: (Please enter all current medications **<u>OR</u>** if you have a list give it to the front desk to be scanned)

____
____
____
____

<u>Allergies</u>: (please enter all known drug allergies)

____
____
____

Social History: (Please circle all that apply)

1.	Not sexually active		Sexually active with one partner
	Sexually active with more than one partner		Same Sex partner
2.	Drug use	IV Drug use	None
3.	ETOH (alcohol)	Less than 1 drink per day	1-2 drinks per day
		3 or more drinks	None
4.	Patient feels safe at home		Patient feels unsafe at home
5.	Never smoked	Quit smoking	
	Smokes less than daily	Smokes daily	

Driving Status: Drives the daytime/ Drives at night

How often do you exercise? Once a day/ Few times a week/ Few times a month/ Never

What is your caffeine use? Once a day/ Several times a day/ Few times a week/ Never

Occupation and Workplace: ____

Review of Systems: Are you currently experiencing any of the following?

(please check **Yes** or **No** for the following)

SYMPTONS	Yes	No		ALERTS	Yes	No
Changing Mole				Allergy to adhesive		
Immunosuppression				Allergy to lidocaine		
Hay fever				Allergy to topical ointments		
Problems with bleeding				Latex Allergy		
Problems with healing				Artificial joints with past 2 years		
Problems with scarring				Artificial Heart Valve		
Rash				Defibrillator		
Chest Pain				Blood thinners		
Fever or Chills				MRSA		
Night sweats				Pacemaker		
Unintentional weight loss				Premedication prior to procedure		
Thyroid problems				Rapid heartbeat with epinephrine		
Diabetes				Pregnancy or planning pregnancy		
Sore throat				Issues with buried sutures		
Blurry vision				Renal dialysis		
Abdominal pain				Decreased renal function		
Bloody stool				Impaired liver function cirrhosis		
Bloody urine				HIV+		
Joint aches				Hepatitis B/C		
Muscle weakness				H/O Leukemia/Lymphoma (circle)		
Neck stiffness				H/O Cold sores/ Oral HSV		
Headaches				H/O Organ Transplant		
Seizures				Breast Feeding		
Cough				H/O Melanoma		
Shortness of breath						
Wheezing						
Anxiety						
Use of supplemental Oxygen						

Payment is to be made at time services are rendered. Any other arrangements must be discussed with the office manager prior to your consultation with the doctor

I, ___________________________ authorize the release of any medical information requested by my insurance carrier to process insurance claims.

MEDICARE PATIENTS:

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology & Cutaneous Surgery Institute for any services furnished to me by that physician. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature: Patient/ Guardian/ POA: ___________________________ **Date:** ___/___/___

HMO & PPO PATIENTS:

I understand that I am responsible for all deductibles and co-payments at the time of service. I further understand should payment be denied due to "Pre-existing illness" , "Non-covered or termination of coverage" I will be responsible for payment of such fees within 30 days of such notification.

Signature: Patient/ Guardian/ POA: ___________________________ **Date:** ___/___/___

Dermatology & Cutaneous Surgery Institute (DCSI), P.A.

Privacy Policy Acknowledgement

I hereby acknowledge I have been presented with the opportunity to read and understand the current HIPAA privacy policy for (DCSI). I acknowledge any changes to this form will only be accepted in writing.

________________________________ **____/_____/____**

Signature (Patient or Guardian) **Date**

Financial Policy

By signing below, you confirm that you have read this policy and understand the following:

- The patient is responsible to inform the office of any contact information changes.
- The patient or responsible party is to keep their account current-accordingly applicable copayments, coinsurance, and deductibles will be collected at the time of service.
- Return checks will incur a $50 service charge. Checks will not be accepted from patients who have had return checks, payment must be made by cash, money order, or credit card.
- Any unpaid balances older than 90 days may be subject to a 1.5% finance charge to be accrued each month if the balance is older than 90 days.
- If your account is forwarded on to a collections agency you will be responsible for any costs incurred in collections of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and legal fees.
- If you have health insurance, we will submit the claims to plans DCSI provides for; however, you are responsible for your account balance.
- Credit balances will automatically be applied to your account for future scheduled appointments. If you do not wish to have the credit applied to future appointments please notify the office manager and a refund check will be issued.
- If you change to a health plan DCSI does not provide for, you will be responsible for the services, and may submit a claim directly to your carrier.
- The patient is responsible to notify our office of any changes to their insurance policy so that we have current information on file. If the patient's insurance coverage changes and we are not notified the patient/responsible party will assume responsibility for any unpaid services by the policy.
- Insurance verification is not a guarantee of benefits and is only an estimation of coverage based on the insurance information available to us from your insurance carrier at the time of verification.
- You are responsible for your deductible at the time of service
- If you have an insurance carrier that requires an authorization, it is your responsibility to make sure the referral is coordinated and received in our office before your procedure.
- You are responsible for any services which are not covered or denied due to: pre-existing limitations, considered cosmetic, or non-covered due to plan limitations.

Please discuss any financial arrangements or payment plans with the Office Manager we will be happy to assist in the management of your account. If you have any questions about the above information, please do not hesitate to speak to the Office Manager.

I have read and understand the above Financial Policy and agree to the policy:

_______________________________ ____________________________________ _____ / ____ / ______

Print Patient Name/Responsible Party **Signature (Patient/Responsible Party)** **Date**

HIPAA AUTHORIZATION FORM

Patient's Full Name

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize *Dermatology and Cutaneous Surgery Institute, DCSI* to disclose my protected health information to the following **person** or **facility**

Name & Relationship to Patient

Address

City, State Zip Code

The specific information that should be disclosed

- ☐ Pathology Reports
- ☐ Office Notes
- ☐ All Records

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING –

Signature of Individual*	Date of Individual's Signature	Date of Birth
Signature of Guardian* or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual