ASSOCIATES IN DERMATOLOGY

HISTORY AND INTAKE FORM

PATIENT NAME: _____

DOB: _____ DATE: _____

PAST MEDICAL HISTORY

(please circle all that apply)

Asthma
Atrial fibrillation
Bone marrow transplantation
Breast cancer
Colon cancer
COPD
Coronary artery disease (heart disease)
Diabetes
End stage renal disease (kidney)
Hepatitis (A, B, or C)
Hypertension (high blood pressure)
HIV / AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism (high thyroid level)
Hypothyroidism (low thyroid level)
Leukemia
Lung cancer
Lymphoma
Pacemaker
Prostate cancer
Radiation treatment
Rheumatoid arthritis
Seizures
Stroke
Valve replacement
None
Other _____

PAST SURGICAL HISTORY

(please circle all that apply)

Artificial joints – which joint/s: _____
Basal cell carcinoma surgery
Colectomy (inflammatory bowel disease)
Coronary artery bypass
Heart transplant
PTCA (percutaneous transluminal coronary angioplasty)
Kidney removed (right, left)
Kidney transplant
Ovaries removed
Prostate removed
Mastectomy
Melanoma surgery
Spleen removed
Squamous cell carcinoma surgery
Hysterectomy; uterine cancer or fibroids
None
Other _____

SKIN DISEASE HISTORY

(please circle all that apply)

Acne
Actinic keratoses (precancer lesions)
Basal cell skin cancer
Blistering sunburns
Eczema
Hay fever / allergies
Melanoma
Precancerous moles (atypical moles)
Psoriasis
Squamous cell skin cancer
None
Other _____

Do you wear sunscreen? Yes No 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)? _____

Any other pertinent family history? _____

ASSOCIATES
IN DERMATOLOGY

Referring Physician: _____

Phone Number for Referring Physician: _____

Primary Physician: _____

Phone Number for Primary Physician: _____

MEDICATIONS

MEDICATION: (Please PRINT all current medications)	DOSAGE:	HOW OFTEN:	REASON FOR TAKING:
	_____ mg		
	_____ mg		
	_____ mg		
	_____ mg		
	_____ mg		
	_____ mg		
	_____ mg		
	_____ mg		
	_____ mg		
	_____ mg		

MEDICATIONS YOU ARE ALLERGIC TO

(Please enter all allergies)

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

(Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily - if yes, how many?_____

Alcohol use:

- None
- Less than one drink per day
- One to two drinks per day
- Three or more drinks per day

What is your occupation? _____

Pharmacy Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

ASSOCIATES
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PATIENT REGISTRATION

(Please Print)

DATE: _____

PATIENT INFORMATION

Patient's Name: _____ SS #: _____
(First) (Middle) (Last)

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Male Female Age: _____ Patient's Date of Birth: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____

Race: _____ Ethnicity: Hispanic / Latino Language: _____
Non-Hispanic / Latino
Other

Marital Status: Married Single If Married, Name of Spouse: _____

If Child - Name of Mother and Father or Legal Guardian: _____

Person Responsible for bill if different than patient:

Name: _____ SS #: _____
(First) (Middle) (Last)

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____ D.O.B. _____ Age: _____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Name of Insurance: _____	Name of Insurance: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber's Date of Birth: _____ Sex: _____	Subscriber's Date of Birth: _____ Sex: _____
Policy or ID #: _____	Policy or ID #: _____
Group #: _____	Group #: _____

ASSOCIATES
IN DERMATOLOGY

PATIENT FINANCIAL AGREEMENT AND MEDICAL CONSENT

- **Insurance Changes -** It is the responsibility of the patient/guardian to provide correct information and notify the practice of any changes to your insurance coverage, so that we can correctly file claims and accurately determine out of pocket costs. The patient is responsible for providing a current referral when/if required.
- **Co-Payments -** Co-payments are due at the time of service. If you are unable to remit your co-payment amount, the practice reserves the right to reschedule your appointment for another day/time that is convenient for you.
- **High Deductible Health Plans -** Due to the recent increase in high deductible health plans, patients with a remaining in-network balance, will be responsible for a deposit, due at the time of service.
    - Charges for all visits will be billed to your designated insurance carrier for services rendered by Associates in Dermatology providers.
    - The pre-payment will be applied to the account and any remaining balance, as determined by the insurance carrier will be billed to the responsible party on the account.
    - This does not apply to Medicare or Medicaid patients.
- **Prior Balances -** Prior balances are due upon receipt of a statement or at the time of a scheduled appointment, whichever comes first. If you are unable to make payment at the time of the scheduled appointment, please contact the billing office to make arrangements for the balance. If you are unable to remit payment, the practice reserves the right to reschedule your appointment for another day/time that is convenient for you.
- **Missed Appointments/No show -** There will be a $ 25 charge for missed appointments in addition to any other charges you may incur. Repeat missed appointments may result in your physician sending a letter discharging you as a patient of the practice. (This policy does not apply to/for federal and state plan beneficiaries.)
    - If you are cancelling or rescheduling an appointment that requires an interpreter. It is your responsibility to call our office 24 hours prior to scheduled appointment time. Failure to do so, you consent to be held responsible for any cancellation/no show fees for these services.
- **Insurance and Billing -** It is your responsibility to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. Associates in Dermatology bills insurance as a courtesy to our patients. Services that have not been paid by your health insurance carrier will become the patient's responsibility to pay in full, which shall include charges incurred for any laboratory testing and pathology. The patient acknowledges and understands that the laboratory/pathology services are separate from the physician's fee.
- **Self-Pay Patients -** It is our policy to collect payment at the time of service, this includes physician fees and/or pathology fees.
- **Phone Calls -** For any phone number provided by you to the practice at which you may be contacted, you consent to receive calls or text messages, included but not restricted to communications regarding billing and payment for items and services, unless you notify the practice to the contrary in writing. Calls and text messages include but are not limited to pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication used by the practice and/or its affiliates, contractors, servicers, clinical providers, attorneys, or its agents, including collections agencies.
- **Collections and Legal Activity -** If Associates in Dermatology does not receive prompt payment, we reserve the right to transfer your balance to outside collections after being 90 days past due. If an account is referred to outside collections, we reserve the right to dismiss the patient from the practice. The account is subject to additional fees incurred by the practice and/or related to the collections activity. Pursuant to Kentucky Revised Statutes (KRS 411.195), if your account requires the practice to use an attorney to recover the amount you owe, either by legal action or by other means, you will be responsible for payment of the practice's reasonable attorney fees and court costs.
    - I authorize all Providers, Nurse Practitioners, and Physician Assistants associated with Associates in Dermatology to release information for the purpose of payment, treatment, and routine healthcare operations, including medical research studies.
    - I authorize payment of medical benefits to all Providers, Nurse Practitioners, and Physician Assistants associated with Associates in Dermatology.

      Your signature indicates your understanding and compliance with this policy.

Print Patient Name	**Patient Signature / Date**
Print Guardian Name (If patient is under 18 years of age)	**Guardian Signature / Date** (If patient is under 18 years of age)

ASSOCIATES IN DERMATOLOGY, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I have received a copy of the Privacy Practices provided by Associates in Dermatology, PLLC.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Signature of Patient / Parent or Guardian Date

My Protected Health Information may be disclosed to:

Self_____ Phone:_____

Spouse / Significant Other_____ Phone:_____

Parent / Guardian_____ Phone:_____

Roommate_____ Phone:_____

Other_____ Phone:_____

Children_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

I give permission for Associates in Dermatology to contact or leave a message regarding test results on the following:

Home Phone Voice Mail Home #_____

Cell Phone Voice Mail Cell #_____

Work Phone Voice Mail Work #_____