



Patient Information Form

Date: _____

Name: _____
(First) (Last)

Date of Birth: ___ / ___ / _____ GENDER: M F Marital Status: _____

SSN #: _____ - _____ - _____

Address: _____ Suite / Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Mobile Phone: (____) _____ - _____

E-Mail: _____

Preferred Contact Method (Circle one): HOME MOBILE WORK

Patient does **NOT** have health insurance coverage.

Insurance Policy Holder (Parent or Guardian):

Name: _____ DOB: ___ / ___ / _____
(First) (Last)

Relationship to patient: _____

Personal Representative

Check here if someone other than the patient is completing this form.

Name: _____ Relationship to patient _____

Authority of Personal Representative to Sign for Patient (Check one):

Patient _____ Guardian _____ Power of Attorney _____ Other _____



Medical History Form

Reason for Visit and Location of Problem: _____

Height: _____ **Weight:** _____

Past Medical History: (Check all that apply. If NONE, please check NONE)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus/ Rheumatoid Arthritis |
| <input type="checkbox"/> Bleeding Disorder (or bleeding issue) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Hyper or Hypo (Circle one) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Fever Blister | | <input type="checkbox"/> NONE |

Do you have a history of Skin Cancer or Skin Disorders?

(Examples: acne, actinic keratosis, basal cell, eczema, melanoma, psoriasis, squamous cell)

Yes ___ No ___ If yes, please indicate condition or disorder: _____

Family History of Melanoma? (circle one) **Yes** **Relation:** _____ **NONE**

Medications: _____

(Enter all current medications including non-prescription and birth control: if none mark N/A)

Allergies: _____

(Please enter all allergies including allergy to medications, if none mark N/A)

Review of Symptoms: (Check all that apply. If NONE, please check NONE)

- | | |
|---|--|
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Unintentional weight loss |
| <input type="checkbox"/> Problems with scarring/keloids | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Fever or Chills | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> NONE |

Alerts: (Check all that apply. If NONE, please check NONE)

- | | |
|--|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to Topical Antibiotics | <input type="checkbox"/> Require antibiotics prior to surgical procedure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Rapid heartbeat with Epinephrine |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Are you pregnant or currently trying to get pregnant? Notify physician verbally | |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> NONE |

Referring Physician / Primary Care Physician: _____

Preferred Pharmacy Name: _____ **Telephone:** (___) ___ - ____

Address (or cross street): _____ **City:** _____



This is a requirement by the government center for medical services based on the merit-based payment system.

Do you have a Living Will? Yes No

Do you have a Power of Attorney? Yes No

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Specialist In Dermatology & Cosmetic Medicine (Lawrence E. Samuels, M.D. Inc.) to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Please initial on each line that you have read and understand each statement.

_____ *I hereby authorize the release of any information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or for that portion not covered by my insurance. I further understand that if there is any delay or dispute regarding my insurance, I will be responsible for payment on my account within a reasonable period of time. I understand that I will be responsible for 100% of all cosmetic charges incurred in this office, regardless of any provider discount through my insurance carrier. **I understand that it is my responsibility to obtain all necessary insurance referrals from my PCP. If services are denied due to lack of an insurance referral, I am responsible for payment in full.**

_____ *I understand that Specialist in Dermatology and Cosmetic Medicine has adopted strict Privacy Practices in Compliance with HIPAA regulations. Specialist in Dermatology and Cosmetic Medicine reserves the right to change its practice to maintain compliance with privacy regulations. More complete review of their privacy practices are available upon request. In the event of an emergency, Specialist in Dermatology and Cosmetic Medicine will disclose information related to your emergency condition.

FINANCIAL AGREEMENT

Please initial each line – to acknowledge that you have read and understand our office policies.

- We will ask to see, scan and enter your insurance card/cards at the time of your visit.
It is your responsibility to be sure you give us your most updated information at the time of each of your visits. If you do not have the most updated insurance card/cards you will be considered a self-pay patient and may be asked to pay upfront \$75 for the office visit and then payment due in full after visit is completed.
- It is your responsibility to know how your insurance policy works.
If your insurance requires a referral it is your responsibility to acquire that referral before the appointment date and be sure we have it in our office prior to your appointment.
- If we participate in your insurance, you are required to pay for any co-payments, deductibles, and coinsurance due. Co-payments will be collected at the time of your visit. Payment for the remaining balance is due at the time your statement is received or your next visit, whichever comes first. All cosmetic services are due at the time of services.
- If your balance is still unpaid upon the receipt of your third mailed statement we will try and contact you one more time before sending you to our Collection Company. A \$25 Collection Company Fee will be applied.
- Please give us a 24-hours' notice for all cancellations. There are many patients that need to get in that we can offer these appointments to. If we do not get a notification from you, your account will be charged a \$50.00 NO SHOW FEE.
- The "Guarantor" is the policy-holder for the insurance plan covering the patient or the party responsible for self-pay charges if patient is not covered by insurance. It is the expectation of this office that in case of a divorce, the two parental parties will handle payment arrangements without the involvement of our office. We will only bill the Guarantor.
- You may have a biopsy taken in the course of today's treatment. Biopsy samples are sent to an outside lab and you will receive a separate bill from the lab/pathologist.
- We will charge a 3% Credit Card Processing Fee on charges of \$100 or more. No processing fee for debit, checks or cash.

Signature: _____ Date: _____