Associates in Dermatology, SC ***Medical History Intake:***

Patient Name:______________________________ DOB: ____/____/_____

Referring Physician:______________________ Referring Physician's Address: ______________________

Primary Reason for Appointment:______________________________

How long have you had this problem:______________________________

Occupation: ______________________________

List all Known Drug Allergies:______________________________

Are you allergic to: Tape (Y / N) Xylocaine (local anesthetic) (Y / N) LATEX (Y / N)

List all medications: ______________________________

____

Past Medical History: (Please check all that apply) Height_____ft_____in Weight________lbs

Yes/No			Yes/No		
☐	☐	Anxiety	☐	☐	High Cholesterol
☐	☐	Arthritis	☐	☐	Histoplasmosis
☐	☐	Asthma	☐	☐	Hypertension
☐	☐	Atrial Fibrillation	☐	☐	Hyperthyroidism
☐	☐	Atypical Moles / Dysplastic Moles	☐	☐	Hypothyroidism
☐	☐	Basal Cell Skin Cancer ________________	☐	☐	Kidney Disease
☐	☐	Cancer – Date/Type ________________	☐	☐	Liver Disease
☐	☐	Cardiac Arrhythmia	☐	☐	Lupus
☐	☐	Clotting Disorder	☐	☐	Melanoma ________________
☐	☐	Cold Sores	☐	☐	Osteoporosis
☐	☐	Coronary Artery Disease	☐	☐	Other ________________
☐	☐	Crohn's Disease	☐	☐	Psoriasis
☐	☐	Depression	☐	☐	Pulmonary Embolism
☐	☐	Diabetes	☐	☐	Squamous Cell Skin Cancer ________
☐	☐	Eczema	☐	☐	Stroke
☐	☐	HIV	☐	☐	Tuberculosis
☐	☐	Hepatitis B or Hepatitis C	☐	☐	Ulcerative Colitis

Is there anything else about your medical history which would be useful or important for the Provider?

____

Have you had surgery in the past year? Y / N If yes, describe ______________________________

Family History: (Please check all that apply)

☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blood Coagulation Disorder
☐ Chronic Depression
☐ Crohn's Disease
☐ Diabetes
☐ Dysplastic/Atypical Moles
☐ Lupus
☐ Melanoma
☐ Cancer
☐ Pancreatic Cancer
☐ Psoriasis
☐ Rheumatoid Arthritis
☐ Squamous Cell Cancer
☐ Ulcerative Colitis

Social History:

☐Smoker ☐Non-smoker ☐Past Smoker

Alcohol intake: ☐None ☐Occasional
☐Moderate 5-7 drinks per week
☐Heavy (more than 2 per day)

Have you ever used a tanning bed? Y / N

Do you use sunscreen regularly? Y / N

Associates in Dermatology, SC
Patient Registration Form

Today's Date:____________________

Patient Name: ____ Preferred Name:________________________
First Middle Last

Sex: M F (Please circle) Date of Birth: ____/_____/______ Security Number: _ _ _ - _ _ - _ _ _ _
MM/DD/ YYYY

Home Address: ______________________________________ _____________________________________ ____________
Street or PO Box City and State Zip Code

Patient Phone number(s): H)_____________________C) _______________________W) _______________________

Email Address: ____ Primary Care Physician:_____________________________

Occupation:____Place of Employment: ______________________________

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner

Spouse: ____Spouse Date of Birth: ______/______/________
First Middle Last MM DD YYYY

Spouse's Place of Employment and Phone # ____

Language: ☐English ☐ Spanish ☐other __________ Race:____________________Ethnicity:________________

Parent or Person Responsible for Payment: (If Different from Above)

Mother: ___________________________________ Place of Employment:____
First MI Last Phone #:____
Home Address:____

Father: _____________________________________ Place of Employment:____
First MI Last Phone#:____
Home Address:____

Emergency Contact: Name:___________________________Relationship:_____________Phone:_______________

Preferred Pharmacy:__________________________________Preferred Lab:_____________________________________

Medical Insurance Information: Insurance Company:____

Insured's Name:____ Date of Birth:_____________________________

Medicare #:____ Public Aid #:_____________________________

Please sign name if on Medicare: ____

Notice: If your Insurance Co. is Not one that we bill, YOU are responsible for submitting claims to your Insurance Co.

IF INFORMATION IS REQUIRED FROM MY INSURANCE CO., PHYSICIAN, OR LABORATORY, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NEEDED.

Patient Signature____ Date:_____________________

Associates in Dermatology, SC
Notifications Form

*****Notifications:*** We may need to contact you in the future regarding upcoming appointments, lab/ pathology reports, and insurance questions.

Please mark which method(s) of contact you give our office permission to use:

☐ Email notification: e-mail:________________________________
☐ Phone
☐ Text Message : Cell # for text ____________________________

Patient Authorization for Use & Disclosure of Protected Health Information:

I_____________________________________, give my permission to release my medical information and
Patient Name
lab results to the following persons:

Name	Relationship
________________________________	______________________________
________________________________	______________________________
________________________________	______________________________

Print Patient Name:____

Date of Birth:________________________

Signature of Patient:____

Today's Date:________________________

********This information will remain in effect, until revoked in writing, by patient.***

Receipt of Notice of Privacy Practices Written Acknowledgement:

I,_____________________________________, have received a copy of Associates in Dermatology's
Patient Name
Notice of Privacy Practices.

____ ____________________
Signature of Patient Date

Associates in Dermatology, SC
1404 Eastland Dr. Ph: 309-662-8813 Fax: 309-662-6835

FINANCIAL POLICY

PAYMENT FOR SERVICES:

- Your insurance plan requires your co pay be paid at the time services are rendered. If you are unable to pay your co pay at the time of your appointment, you may be asked to reschedule your appointment. **Failure to pay this amount when due is a violation of our contract with your insurance carrier and is your financial responsibility for coverage**. We are responsible to report to all insurance carriers refusal to pay issues

- **Further, you are required to pay for invoiced services when you receive your first statement from your physician.** We have an expectation that you will honor this relationship of trust with your physician and our office and pay timely when invoiced. Failure to do so timely may be just cause to suspend or terminate all future services at Associates in Dermatology. We gladly accept Cash, Checks, Master Card and Visa credit card for payment of services.

- Returned checks, **unpaid balances older than 60 days, and failure to pay account balances timely as promised may subject your account to external collection fees and possible termination from the practice**. If you have situations that present difficulty in paying for your services, call our Billing Office at 309-662-8813, ext. 6.

INSURANCE AND BILLING:

- **Associates in Dermatology will bill your insurance co. as a courtesy to you** to help you achieve the maximum benefits under your plan. To do this, we need your cooperation with our payment policy. We will submit fees for our services to most insurance carriers, however, **we expect payment of all your services within 60 days, either from your insurance company or yourself.** It may become necessary for you to pay your account in full if your insurance co. fails to pay for your services timely or within 60 days.

- It is your responsibility to understand your policy plus all coverage and benefits, including pre-certification, in and out-of-network benefits, referral, and authorization requirements.

- Periodically, you will be asked to update your demographic and insurance info including providing our office with copies of your insurance card(s). **Assoc. in Dermatology does not bill for or participate in Worker's Compensation, Motor Vehicle Accident Claims or get involved with third party litigation.

- **We participate in most major insurance plans, but not all.** Your insurance is a contract between you, your employer, and the insurance co. We are often not a party to that contract and the services charged are your responsibility to see that they are paid on time. **Please make sure we are an in-network provider with your insurance plan before you have services provided to avoid any unexpected expenses from denied services.**

APPOINTMENTS:

- Associates in Dermatology utilizes scheduled patient appointments to see the physician or nurse practitioner and does not accept walk-in visits. Your cooperation in cancelling your scheduled appointment well in advance of the appointment allows us the opportunity to offer your appointment to another patient who needs medical care. **Timely cancellations are a 48-hour notice.**

- No Shows: **If you no show three or more of your scheduled appointments, you may be dismissed from the practice for failure to call and cancel timely.**

My signature below constitutes acknowledgement and acceptance of this policy.

____________________________ ______________________________________ Date: ____/____/____

Print Name Patient or Guarantor Signature