Date: _____

DERMATOLOGY CONSULTANTS
PATIENT HEALTH INFORMATION

Account _____ Provider _____

Patient Name _____ Nickname _____

Address_____

City_____ State _____ Zip Code_____

Home phone_____ Work phone_____

Mobile phone _____

Sex _____ Date of Birth _____ Age _____

SS# (Medicare patients only) _____

Marital Status: Married _____ Single_____

Employer: _____ Occupation: _____

Responsible Party/Guarantor_____

Family Doctor _____ Phone# _____

In case of emergency, contact _____ Relationship _____

Address_____ Phone# _____

If patient is a minor: Mother or Father's name _____

Address (if different from above) _____

I selected this office because:

____ Yellow Pages Internet
____ Dermatology Consultants website
____ Other reasons (location, reference, etc.)

Who may we thank for your referral? _____

FAMILY HISTORY

Has anyone in your family been seen here before: _____ Yes _____ No
List names and ages of household members:
(Place an "X" by those who have been seen here before:

_____ _____ _____

Do any family members have a history of any of the following: (please circle all that apply):

Melanoma	Skin Cancer	Abnormal moles	Asthma
Hay fever	Eczema	Psoriasis	Adult acne
Genetic disorders	None		

Other skin problems in close family members: _____
_____

PAST MEDICAL HISTORY

List other problems you have with your skin, hair, or nails: _____

_____

List all past major illnesses and operations _____

_____

List **ALL** medications you are currently taking (including over-the-counter products or medications such as herbs, vitamins, or other supplements): None _____

Aspirin	Birth control pills	Heart medicines (list)
Blood thinners	High blood pressure pills (list)	
_____	_____	_____
_____	_____	_____

Do you smoke? _____yes _____no Drink alcohol? _____yes _____no

Please circle all that apply:

X-ray treatments	Epilepsy/seizures	Heart trouble	Skin infection
Severe headaches	Asthma	Thyroid condition	HIV positive
Heart pacemaker	Chicken pox	Eczema	Anemia
Fainting tendency	Bad scars/keloids	Venereal disease	Cancer
Diabetes	Hay fever	Urticaria (hives)	Hepatitis
Kidney problems	Bleeding tendency	Rheumatic fever	TB
Melanoma	Artificial heart valve	Liver disease	Kidney disease
Artificial joints	Tanning bed use	Skin cancer	Immune system disorder
Cosmetic surgery	None of the above		

Women only:

Are you, or might you be, pregnant? _____yes _____no

Do you plan to become pregnant in the near future? _____yes _____no

ALLERGIES

Are you allergic to any medications? _____yes _____no

Allergic to:

_____ Penicillin _____Aspirin _____Sulfa drugs

_____ Erythromycin _____ Others (please list) _____

Preferred Pharmacy _____ Location/Phone _____

EMERGENCY CONTACT

Name _____ Relationship to Patient_____

Address _____ Phone _____

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. As outlined in our Notice, the terms of our Notice may change. If our Notice is changed or modified, you may obtain a revised copy by requesting from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care options. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care options. You have the right to revoke this consent, in writing, except where we have already made the disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax of this consent is as valid as though original.
3. I may revoke this consent at any time except where information has already been released. This consent is valid until revoked by me in writing.

_____	_____	_____
Signature	Printed Name	Date

Parent, Guardian, Custodian or General Agent authorizing and consenting to medical treatment.

_____	_____	_____
Signature	Printed Name	Date

CONTACT INFORMATION

I, _____, give the office of Dermatology Consultants permission to speak with the following family members, spouse, roommates, etc., regarding billing issues, lab results, or any other information pertaining to my treatment and care:

Family members, spouse, roommate, etc.

_____ _____

_____ _____

Please list the contact numbers below:

Work #_____ Can we leave a message? _____

Home #_____ Can we leave a message? _____

Mobile #_____ Can we leave a message? _____

Can we leave a voice message regarding medication refills? _____ yes _____no
Can we send you a text message as an appointment reminder? _____yes _____no

E-mail address _____
Print clearly

Signed_____

Date_____

THIS CONTACT INFORMATION SHEET WILL EXPIRE IN 12 MONTHS FROM THE ABOVE DATE !!!!!!!

Insurance

Dermatology Consultants does not accept any insurance plans. We will give you a copy of our superbill to send to your insurance company. Some out-of-network benefits may apply. Please contact your insurance plan for these benefits.

Medicare

We accept Medicare assignment and will bill Medicare for any covered charges. However, any calendar year deductible amounts are due at the time of your visit. Medicare secondary plans will be billed once payment is received from Medicare. Dermatology Consultants may be out of network for your secondary plan. If so, or if there is no secondary insurance available, the patient will be billed for any remaining balance. Please bring your Medicare and supplemental insurance cards to each visit.

Referral Authorization

Referrals must be obtained by the patient prior to the visit. If a referral is required by your insurance plan and one is not obtained prior to the visit, the patient will be responsible for payment when services are rendered.

Authorization

I authorize release of medical record to determine liability for payment or treatment and to obtain reimbursement.

I assign all medical benefits for office visits to Dermatology Consultants. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

_____ _____
Signature Date