Name_____ Age_____ Date_____

Reason for today's visit: (chief complaint)

_____

_____

Medical History and Systems Review

Have you had problems with any of the following?(Check all that apply)

	No	Current	Past	Please explain
General Health	☐	☐	☐	_____
Eyes	☐	☐	☐	_____
Ears/Nose/Throat/Mouth	☐	☐	☐	_____
Heart	☐	☐	☐	_____
Lungs	☐	☐	☐	_____
Stomach/Bowel	☐	☐	☐	_____
Kidneys/Bladder	☐	☐	☐	_____
Arthritis/Muscles	☐	☐	☐	_____
Skin	☐	☐	☐	_____
Headaches/Seizures	☐	☐	☐	_____
Psychological	☐	☐	☐	_____
Thyroid/Diabetes	☐	☐	☐	_____
Blood	☐	☐	☐	_____
Allergic/Immunologic	☐	☐	☐	_____

Females only: ☐ Currently pregnant ☐ Abnormal periods ☐ Yeast infections ☐ On birth control
☐ Planning pregnancy ☐ Breast feeding

Do you take blood thinner or aspirin? ☐ **Yes** ☐ **No**

Cancer(s): (List Type, Date, Treatment)_____

_____

Current Medications:_____

_____

_____

_____

Medication Allergies: (Circle) NONE Sulfur Penicillin Lidocaine Codeine Tetracycline Band-aids

Others: (list)_____

_____

Family History

Check the following medical conditions that have occurred in your family:

	Mother	Father	Blood Relative
Allergies	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Hay Fever	☐	☐	☐
Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Other Skin Problems	☐	☐	☐ Type:_____

Social History: Do you live alone? ☐ No ☐ Yes Do you smoke? ☐ No ☐ Yes- how much?_____

Do you drink alcohol? ☐ No ☐ Yes-amount?____ Do you use recreational drugs? ☐ No ☐ Yes-frequency____

Occupation_____ Hobbies/leisure activites_____

How much time do you spend: in the sun?_____ Tanning bed?_____

MA initials:_____ Date:_____

Reviewed:_____ Date:_____

Fayette Area Dermatology

Patient Information

Patient Name _____ Birthdate ____/____/____ ☐M ☐F

Address: _____ City_____ State____ Zip_____

SS# _____ Email: _____ Referring Physician: _____

Home Phone _____ Cell_____ Work_____

Emergency Contact

Name: _____ Relation: _____ Phone#:_____

Parent, Spouse or Responsible Party (if different from patient)

Name: _____ Relationship:_____ Home #_____

Date of Birth:_____ SS#_____ Work# _____

Address: _____ City_____ State____ Zip_____

PRIMARY INSURANCE COVERAGE **PLEASE PROVIDE YOUR CURRENT INSURANCE CARD**

Insurance Co Name: _____ Policy# _____ Group#_____

Insured's Name (*Policy Holder*) _____ Relationship_____ DOB_____

SS#_____ Company Name:_____ Phone: _____

SECONDARY INSURANCE COVERAGE

Insurance Co Name: _____ Policy# _____ Group#_____

Insured's Name (*Policy Holder*) _____ Relationship_____ DOB_____

SS#_____ Company Name:_____ Phone: _____

Authorization for Release of Information

I authorize Fayette Area Dermatology to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. I understand I have the right to revoke this authorization at any time. I understand I have the right to refuse to sign this authorization.

If you would like for us to do any of the following please initial and sign below.

___☐___OK to leave message on answering machine regarding medical/financial info
___☐___OK to leave message with spouse regarding medical/financial info
___☐___OK to leave message with _____ regarding medical/financial info

Patient Signature _____ Date_____

Fayette Area Dermatology

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth:_____

I had an opportunity to review the Notice of Privacy Practices for the above named practice, and understand that I may have a copy to take with me if I choose.

_____ _____

Patient Signature or Responsible Party Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- □ An emergency existed & a signature was not possible at the time.
- □ The individual refused to sign.
- □ A copy was mailed with a request for a signature by return mail.
- □ Unable to communicate with the patient for the following reasons:

_____

Prepared By: _____ Signature _____ Date:_____

You have the right to refuse treatment at any time; however, once treatment is rendered, payment is required. Payment is expected at the time of service.

Private Pay- I understand & agree that payment is due & payable at the time of service.

Health Insurance- I understand that each time I am seen in the office for an evaluation and/or treatment an office visit can be charged in addition to any other charges. I understand that outside laboratories may be used for skin biopsies and/or cultures and that I may receive a separate bill for these services. I understand & agree that I will need to provide a current copy of my insurance card to the office staff at the time of each visit. I fully understand that I am financially responsible for all monies not covered by my insurance provider including but not limited to deductibles, co-payments, coinsurance or any unpaid portion of the claim.

Medicare: I understand that I am responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of service. Our billing service will file the claim for you and then you will be billed according to the amount due.

I understand that checks are not accepted for cosmetic procedures or products. We do accept checks, credit cards or cash for medical services rendered and/or copays. I do understand there will be a $25.00 fee charged for any return checks.

Cancellation Policy: You agree to a charge of $25.00 for any appointment cancelled less than 24hours in advance, or if you fail to show up for your appointment. If you fail to cancel or keep a cosmetic appointment, you will forfeit your deposit.