□ *New Patient* □ *Returning Patient* □ *Ins. Change* □ *Address Change* □ *Name Change*

Patient Information

Patient Name: ____

Marital Status: □ Single □ Married □ Widowed □ Separated SS#_______________________

DOB: _____/_____/_____ Birth Sex: □ Male □ Female

Primary Care Physician Name: ______________________ Phone: ________________

Referring Physician Name: ______________________ Phone:________________

Emergency Contact Information

Name: ______________________ Relationship: ____________ Phone#: ______________

Parent, Spouse, or Responsible Party Contact Information

Name: ______________________ Relationship: ____________ Phone#: ______________

SS#______________________ Work#______________________

Address: ______________________ City: __________ State: ____ Zip Code: ________

Patient Contact Information

Home # ______________ Cell # ______________ Work # ______________

Preferred Contact Method: □ Home □ Cell □ Work □ Other: ______________

Email Address: ____

Home Address: ______________________ City: __________ State: ____ Zip Code: ________

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

Insurance Co Name: ______________ Policy# ______________ Group# ______________

Policy Type: □ PPO □ POS □ HMO □ Medicare □ Other: ______________

Insured's Name (*Policy Holder*) ______________________ Relationship: ____________

DOB: _____/_____/_____ SS#______________ Phone # ______________

Company Name:____

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

Insurance Co Name: ______________ Policy# ______________ Group# ______________

Policy Type: □ PPO □ POS □ HMO □ Medicare □ Other: ______________

Insured's Name (*Policy Holder*) ______________________ Relationship: ____________

DOB: _____/_____/_____ SS#______________ Phone # __________Company Name:______________

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______________________

Medical History

Name ____ Age ______ Date ______________

Reason for today's visit: (chief complaint)

____

____

Medical History

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	☐	☐	☐	____
Kidney/Bladder	☐	☐	☐	____
Arthritis/Muscles	☐	☐	☐	____
Skin	☐	☐	☐	____
Headaches/Seizures	☐	☐	☐	____
Psychological	☐	☐	☐	____
Thyroid/Diabetes	☐	☐	☐	____
Blood	☐	☐	☐	____
Allergic/Immunologic	☐	☐	☐	____

Females only: ___ Currently Pregnant ___ Abnormal Periods ___ Yeast Infections
___ Planning Pregnancy ___ On Birth Control ___ 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: ____________________________________

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 Problem	☐	☐	☐

Social History

Do you live alone? ___No ___ Yes

Do you drink alcohol? ___No ___Yes-amount? _________

Occupation: ______________________________

How much time do you spend in the sun? ______

Do you smoke? ___No ___Yes-frequency? ___ _____________

Do you use recreational drugs? ___No ___Yes-frequency? ____

Hobbies/leisure activities: _______________________________

Tanning bed? ____

MA Initials: ________________ Date: _________________

Date Reviewed: _____________ Date: _________________

FAYETTE AREA DERMATOLOGY

Name:______________________________________Date:____________

MIPS Questionnaire

(Please complete and return to the nurse)

1. Smoking Status:
   - o Current every day smoker
   - o Former smoker
   - o Never smoker
   - o Heavy tobacco smoker
   - o Light tobacco smoker

2. Influenza Immunization:
   - o Influenza Immunization previously received during influenza season
   - o Influenza Immunization not administered due to patient allergy
   - o Influenza Immunization not administered because patient refused

3. Pneumonia Vaccination Status for Older Adults:
   - o Pneumococcal Vaccination previously received
   - o n/a

4. Melanoma Status: Do you have a history of melanoma?
   - o Yes
   - o No

5. Current medications: Do we have an updated list of your medications?
   - o Yes
   - o No

6. Advanced Care Plan for adults 65 and older:
   - o Do you wish to have full cardiopulmonary resuscitation efforts to be made?
     - o Yes
     - o No

- Do you wish to have a breathing tube if it is required for life saving measures?
  - Yes
  - No

- In the event that your heart were to stop, do you want to have chest compressions or an automated external defibrillator to restart the heart if it is required for life saving measures?
  - Yes
  - No

- Do you have a living will?
  - Yes
  - No

- Do you have a healthcare proxy?
  - Yes
  - No
  - If yes, please provide name and contact information for healthcare proxy ____

What is your email address? ________________________________

Who is your primary Provider? ______________________________

*Please complete and return to the nurse

Privacy Statement

You have the right to review our privacy note, request restrictions, and revoke consent in writing after you have reviewed our privacy notice.
Signing below signifies that you have had the opportunity to view our Notice of Privacy by requesting a copy or reading a copy located in the waiting room and you agreed to the privacy policy of our office.

By signing below, you acknowledge you have read, understood, and agreed to the Dermatology Financial Policy and our Notice of Privacy Practices.

Print Patient Name: ____

Signature of Patient/Insured/Guardian: ________________________ Date: _________

Printed Name of Patient/Insured/Guardian: _____________________ Date: _________

Signature of Office Representative: ___________________________ Date: _________

Please list the names of the persons to whom we may disclose the patient's private health information and state how the individual is related to the patient:

Name: ____________________________________ Phone #: ___________________

Relationship to Patient: _______________________ *Expiration Date: _____________

Name: ____________________________________ Phone #: ___________________

Relationship to Patient: _______________________ *Expiration Date: _____________

Name: ____________________________________ Phone #: ___________________

Relationship to Patient: _______________________ *Expiration Date: _____________

*Expiration Date = Date the ability to disclose the patient's private health information expires. If there is no expiration date, please leave blank.

FAD
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 I 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. INITIAL BESIDE ONES THAT APPLY!

Self-Pay: I understand & agree that payment is due & payable at the time of service. ______ Initial

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 & 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. ______ Initial

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. ______ Initial

Payments: We do accept checks, credit cards or cash for medical services rendered and/or copays. I do understand there will be a $35.00 fee charged for any return checks. ______ Initial

Cancellation Policy: You agree to a charge of $35.00 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. ______ Initial