

Dermatology Medical History Form

Name: _____ Age: _____ DOB: _____
 Height: _____ Weight: _____ Referring Physician: _____

Y N Pacemaker Y N Defibrillator Y N Asthma Y N Hay Fever Y N Seasonal Allergies Y N Eczema Y N Psoriasis Y N Diabetes controlled by (circle) Diet Medication Insulin Y N High Cholesterol Y N High Blood Pressure Y N Stroke Y N Heart Attack Y N Congestive Heart Failure (CHF) Y N Heart Murmur Y N Heart Valve Problem Y N Have you ever been told to take Antibiotics before dental procedures Due to a heart murmur, heart valve, Or artificial joint? Y N Acne Y N Rosacea Y N Thyroid Disorder	Y N Kidney Problems (What Type?) Y N Arthritis Y N Melanoma Y N Basal Cell, If Yes, Where: _____ When: _____ Y N Squamous Cell, If Yes, Where: _____ When: _____ Y N Artificial Joint, If Yes, Where: _____ Y N Appendix Removed Y N HIV or AIDS Y N Hepatitis: A B or C (please circle) Y N Liver Cirrhosis Y N Liver Problems (What Type?) Y N Blistering Sun Burns How Many Times: _____ Where: _____ Y N Bleeding Disorder Y N Anxiety Y N Depression Y N Gallbladder Removed Y N Heart By Pass Surgery
Y N Are You Pregnant? Y N Breastfeeding? Y N Planning Pregnancy	Y N Hysterectomy Total or Partial Y N Tubal Ligation (Tubes Tied) Y N Prone to Yeast Infections with antibiotics

Surgeries : _____ Date : _____ Hospitalized : Y N
 _____ Y N
 _____ Y N
 _____ Y N

Other Medical Problems or Surgeries: _____

Medications : _____ Allergies : _____

Skin Type : If first exposed to the sun, without sunscreen would you: (please circle)
 Always Burn - Sometimes Burn - Never Burn - Always Tan

Social History : Do you smoke or use tobacco Y N Do you drink alcohol Y N # Per Week _____

Family History : Circle any conditions affecting a blood relative. Specify which family member on line beside.
 Melanoma _____ Breast Cancer _____
 Psoriasis/Eczema _____ Acne _____
 Allergies _____ Asthma _____
 Basal Cell or Squamous Cell Skin cancer _____

Patient Information Sheet

Patient Last Name : _____ Patient First Name : _____

Mailing Address: Street _____

City : _____ State : _____ Zip : _____

Tele. Numbers : Home : _____ Work : _____ Cell: _____

Date Of Birth : _____

Social Security # : _____

(PLEASE CIRCLE)

Gender : Male / Female Marital Status : S / M / D / W Other? _____

Race: White / Black African American / Other: _____ Patient decline/unknown

Ethnicity: Spanish/Hispanic origin ... Not of Spanish/Hispanic origin.... Patient decline/unknown

Language (speaking): _____ Patient decline/unknown

Employer Name : _____

Employee Status : _____ Retired _____ Full Time _____ Part Time

Student Status : _____ Part Time _____ Full Time

Referring Physician : _____ Telephone : _____

Primary Care Provider : _____ Telephone : _____

Email Address : _____

Emergency Contact :

Last Name : _____ First : _____

Relationship to Patient : _____ Telephone : _____

Insurance Information : Guarantor (person holding the insurance)

Last Name : _____ First Name : _____

Address Of Insured : _____ City : _____ Zip : _____

Date Of Birth : _____ Telephone : _____ Gender : Male / Female

Subscriber Identification # : _____

Relationship to Guarantor : _____

Name of Insurance Company : _____

Party Responsible for Remaining Balance: _____

How did you hear about us : _____

Acknowledgement of Receipt of: Notice Of Privacy Practice

Thank you for choosing Southern Tier Dermatology and Aesthetics for your healthcare needs.

We are required by law to provide you with a copy of our Notice Of Privacy practices. To ensure that our records are accurate, please complete the following information and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

May we leave *appointment information* on:

Home telephone	Yes	No
Cell phone	Yes	No

May we leave *medical information* on:

Answering Machine	Yes	No
Office Voice Mail	Yes	No
Send Through Mail	Yes	No
Send Via Email	Yes	No
Cell Phone	Yes	No

I hereby give permission to release information regarding my Care protected Health Information to the following individuals: (Family members, friends, or others who need to know about my care):

Name Of Person	Relationship	Contact Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ I have received and reviewed the HIPAA Statement

Signature of Patient

Date

Patient Financial Policy
Southern Tier Dermatology & Aesthetics

If we have a contract with your plan, we will file a claim with your insurance company.

The amount for which you are responsible; any deductibles, copays, percentages or non-covered services, Payment is required at the time of service.

If the practice does not participate with your insurance you will be responsible for the total cost of your visit at the time of service.

Southern Tier Dermatology & Aesthetics has contracts with Medicare and with many managed care plans. Please check with our reception staff to determine whether your plan is one of these.

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

For your convenience in paying, this office accepts Master Card and Visa in addition to Cash and Checks.

The office requires a **48 hour notice** for any cancellations or rescheduling of an appointment. If the appointment is not kept, a \$35.00 charge will be billed.

I certify that I have read the financial policy of Dr. Colleen Crandell and her associates, and I agree to abide by the policy.

Signature : _____ Date: _____

Assignments of Benefits

All Insurance Except Medicare

I authorize my insurance company to pay benefits on my behalf directly to Southern Tier Dermatology.

I authorize Southern Tier Dermatology to provide my insurance company, any information necessary to process claims for services rendered to me.

Signature as it appears on your insurance card

Date

Medicare

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Signature as it appears on Medicare card

Date

Medigap

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits to be made on my behalf for any service furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card

Date

Y N Do you or your spouse work in a company which has more than 20 Employees and have coverage through insurance at that job?

Y N Are you covered by any other insurance that makes Medicare secondary?

Surgical and Procedural Acknowledgement

Due to insurance guidelines:

At my appointment I am aware that TWO (2) SKIN ISSUES will be addressed by my provider today, any other issues will need to be addressed at a follow up appointment.

I understand that only TWO (2) procedures will be performed at one visit, unless otherwise determined by my provider.

At a surgical appointment, I understand that only ONE (1) excision will be performed on that day, unless otherwise determined by my provider.

ALL labs, cultures, etc...are sent to LOURDES hospital, unless otherwise specified by the patient.

ALL specimens will be sent for reading to Dermpath Diagnostics. They are highly specialized skin pathologists who diagnose skin related disorders.

I am aware that ALL specimens will be sent to Dermpath, unless I specify otherwise.

I am also aware that I may receive a separate bill from Dermpath Diagnostics for these services.

Patient Signature

Date

Pharmacy Information Sheet

Patient Name : _____ DOB : _____

Primary Pharmacy :

Name : _____

Address : _____

Telephone Number : _____

Fax : _____

Secondary Pharmacy :

Name : _____

Address : _____

Telephone Number : _____

Fax : _____

Mail-In Pharmacy : (if you use one)

Name : _____

Address : _____

Telephone Number : _____

ALL MEDICATIONS PRESCRIBED BY YOUR PROVIDER ARE SENT ELECTRONICALLY TO THE PHARMACY YOU HAVE CHOSEN.....