Deluxe Dermatology

Patient Information

Patient's Full Name:		Date of Birth:
Home Address:		
City:	State:	Zip Code:
Home #:	Work #:	Cell #:
Sex:	Gender Identity:	Preferred Pronoun:
Email Address:		SSN:
Occupation:	Marital Status: Single Married Divorced Separated Widowed	

Additional Information

Emergency Contact:	
Phone Number:	Relationship:

I give consent to Deluxe Dermatology to discuss or release details of my medical care, including test results, medications, appointment, and other information pertaining to my care with my emergency contact.

Primary Care Physician:	Phone #:
Referring Physician:	Phone #:

Insurance

Primary Insurance:	
Policy #:	Group #:
Relationship to Patient: Self Spouse Domestic Partner Parent	
If subscriber other than patient, please complete the following information:	
Subscriber Name:	
Date of Birth:	SSN:

Secondary Insurance:	
Policy #:	Group #:
Relationship to Patient: Self Spouse Domestic Partner Parent	
If subscriber other than patient, please complete the following information:	
Subscriber Name:	
Date of Birth:	SSN:

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HIPAA Disclosure & Financial Responsibilities

1) **Insurance**: Your visit is filed with the carrier for whom our practice has a valid contract. It is the responsibility of the patient to provide and verify *accurate insurance and personal information*. If your insurance requires a referral, it is your responsibility to provide the referral *prior to your visit*. You will be responsible at the time of service for the payment of copays, unpaid deductibles, and past due balances.

2) **Self-pay and cosmetic**: Payment is expected in full at the time of services.

3) **Cancellation and Missed Appointments**:

    a) Office Visit- I understand that it is my responsibility to cancel my appointment 24 hours in advance of my appointment time and date, otherwise a $50 fee will be billed to my account. This is not covered by my insurance plan.

    b) Surgical & Cosmetic Appointments- I understand it is my responsibility to cancel or change my appointment at least 24 hours prior to my appointment time and date, otherwise a $100 fee will be charged to my account. This is not covered by my insurance plan.

4) **Credit Card on File (CCOF)**: Deluxe Dermatology requires a credit card on file for all patients. Should you have an unpaid balance after your visit, we will mail out two statements, if no payment is received after 60 days we will bill the card on file. The card information is stored with security--the same HIPAA compliant software that protects your confidential medical information. By signing this form, you authorize Deluxe Dermatology to bill your card on file. Receipt of any transaction will be forwarded to the home address in our records.

    NOTE: If a credit card is not on file, you will be sent to collections after 60 days of non-payment

5) A $30.00 overdraft charge will be added for any returned checks.

6) I have read the above financial policies and understand my financial responsibilities as a patient. I understand that failure to make a payment when due is basis for legal action and I agree to pay all costs of collection, including court costs and attorney fees.

7) HIPAA: I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to 1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payers. 3) Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of Responsible Party:____Date:_____________

Relationship to Patient:____

Name:

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Reason for Today's Visit

To provide our patients with excellent care, we request you limit visit concerns to one chief complaint.
Alert staff immediately if you need to have records sent to our office from another physician.

Cosmetic consults will require a separate cosmetic consult appointment.

Concern:	Location:
Prior Treatments:	

Past Medical History

Mark All That Apply:

Anxiety	COPD	Hepatitis	Hypothyroidism
Arthritis	Coronary Artery Disease	Hypertension	Leukemia
Asthma	Depression	HIV/AIDS	Lymphoma
Atrial Fibrillation	Diabetes	High Cholesterol	Seizures
Bone Marrow Transplant	End Stage Renal Disease	Hyperthyroidism	Stroke

Cancers Other Than Skin (Type, Location, Treatment):______________________________

Additional Medical Conditions:______________________________

Pregnant or planning a pregnancy	Blood thinners
Pacemaker and/or Defibrillator	Heat / Cold intolerance
Artificial joints within past two years	Easy bruising
Artificial heart valve	Skin rash
Need premedication or antibiotics prior to surgery	New / Changing skin lesion(s)
Allergy to adhesive	Hives
Allergy to latex	Eczema
Allergy to Lidocaine or anesthetics	Hay fever / Seasonal allergies

Past Surgical History

None Or List all past surgeries & year: ______________________________

____

Family History

Please write if the following relatives had Melanoma, skin cancer, arthritis, high blood pressure, diabetes, cancer, or allergies?

Mother:____________ **Sister:**____________ **Daughter:**____________
Father:____________ **Brother:**____________ **Son:**____________

Skin Disease History

If you have had any of the following skin conditions, provide details below (location, treatment, and date):

SKIN CANCERS

Basal Cell Carcinoma ____________
Melanoma ____________
Precancerous Moles ____________
Squamous Cell Carcinoma ____________
Additional Skin Conditions: ____________

SKIN CONDITIONS

Acne	Herpes / Cold Sores
Actinic Keratosis	Lupus
Dry Skin / Eczema	Psoriasis
Flaky / Itchy Scalp	Sun Sensitivity

Do you wear Sunscreen: No Yes If yes, what SPF?_______

Tanning salon usage: No Yes

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Medications

Please list any prescription and non-prescription medications including pain relievers you are currently taking

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Additional Medications:____

____

Allergies

List all allergies and reaction(s), including medication, food, and environmental.

No known allergies

1.	2.

Additional Allergies:____

Social History

Tobacco Usage:

Never Former Current, If a smoker, number of packs per day: ____ Total years: _____

Alcohol Usage:

None Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

Recreational Drug Use:

No Yes, Substance and frequency:____

Flu Shot:

No Yes; Year of most recent vaccine:____________

COVID vaccine:

No Yes; Manufacturer:_________________ Number of shots:_________

Pneumonia vaccine (65+ only):

No Yes; Year of most recent vaccine:____________

Pharmacy Information

Pharmacy Name:	Phone #:
Pharmacy Address/Location:	