DERMATOLOGY UPDATED MEDICAL HISTORY FORM

Name:_____Age:_____Dob:_____

Height: _____Weight: _____Referring Physician:_____

Y / N Pacemaker	Y / N Kidney problems (What type)
Y / N Defibrillator	Y / N Arthritis
Y / N Asthma	Y / N Melanoma
Y / N Hay Fever	Y / N Basal Cell, if yes Where: When:
Y / N Seasonal Allergies	Y / N Squamous Cell, if yes Where: When:
Y / N Eczema	Y / N Artificial Joints
Y / N Psoriasis	Y / N Appendix removed
Y / N Diabetes controlled by (circle) Diet Medication Insulin	Y / N Blistering Sunburn Number of times: Where:
Y / N High Cholesterol	Y / N HIV or AIDS
Y / N High Blood Pressure	Y / N Hepatitis A B or C (please circle)
Y / N Stroke	Y / N Liver Cirrhosis
Y / N Heart Attack	Y / N Liver Problems (What type?)
Y / N Congestive Heart Failure (CHF)	Y / N Bleeding disorder
Y / N Heart Murmur	Y / N Anxiety
Y / N Heart Valve Problem	Y / N Depression
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 Skin Cancer Removal , if yes Location_____ Dr:_____
Y / N Acne	Y / N Gallbladder Removed
Y / N Thyroid Disorder	Y/ N Are you Pregnant
Y / N Hysterectomy Total or Partial (Please circle)	Y / N Are your breast feeding
Y / N Tubal Ligation (Tubes Tied)	Y / N Are planning pregnancy
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 exposure 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 Type _____ How Much
Do you Drink Alcohol? Y / N # Per Week_____

Family History: Circle any condition affecting a blood relative. Specify which family member on line beside.
Melanoma_____ Breast Cancer_____
Psoriasis _____Acne_____
Allergies _____Asthma_____
Basal Cell or Squamous Cell Skin Cancer_____

Patient Demographics

Patient Last Name: _____ Patient First Name_____

Mailing Address: Street: _____

City: _____ State:_____ Zip:_____

Tele. Numbers: Home_____Work:_____Cell:_____

Date of Birth: _____ Social Security #:_____ Gender: Male / Female

Email Address: _____ Marital Status: S / M / D / W/ Other? _____

Pharmacy Name: _____ City_____ Mail in pharmacy: _____

Race: White / Black African American? Other _____ Patient declined/ unknown

Ethnicity: Spanish / Hispanic……. Not of Spanish/Hispanic origin……Patient declined/ unknown

Language Speaking: _____Patient declined/ unknown

Employer Name_____
Employment Status: _____Retired _____Full time _____Part time

Party Responsible for remaining balance_____
Student Status: _____ Full time _____Part Time_____

Referring Physician: _____ Telephone: _____

Primary Care Physician: _____ Telephone: _____

How did you hear about us?_____

SOUTHERN TIER DERMATOLOGY UPDATED SPECIMEN PROCESSING POLICY

If Southern Tier Dermatology participates with your insurance plan, your specimens will be processed by our in house laboratory and we will bill your insurance. You will be responsible for the balance according to your insurance policy guidelines.

If Southern Tier Dermatology does NOT participate with your insurance plan, your specimens will be processed by DermPath Diagnostics. They will bill your insurance and you will be responsible for the balance according to your insurance policy guidelines.

If you have an insurance plan that requires your specimens to be processed by a particular laboratory to avoid out-of-network charges (Lourdes & United Health Services employees)
Please identify that laboratory here: _____

If you do not inform our office of this information, you will be responsible of any copays, coinsurances or deductibles that result in the processing of your specimen by another laboratory.

_____ _____
Signature of patient or guardian Date

HIPAA

MAY WE LEAVE APPOINTMENT INFORMATION ON? (Please Circle)

Home Telephone Yes No Cell Phone Yes No

MAY WE LEAVE MEDICAL INFORMATION ON? (Please Circle)

Answering Machine Yes No Cell Phone Yes No

Office Voicemail Yes No Send through mail Yes No

Send through email Yes No With another person Yes No

I hereby give permission to release information regarding my care protected health information to the following individuals: (Parents, Family members, friends or other who need to know about health care)

Name of person:	Relationship:	Contact phone number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

___I have received and reviewed the HIPPA statement

_____ _____

Signature of Patient or Guardian Date

SOUTHERN TIER DERMATOLOGY UPDATED INSURANCE INFORMATION

If your insurance requires a referral it is your responsibility to obtain one prior to your visit.

Primary Insurance Information:

Policy holders name: _____ DOB_____ Gender M F

Policy holders address (if different than the patients address)

_____

Policy holder' s insurance number: _____

Relationship of the policy holder to the patient: _____

Secondary Insurance Information:

Policy holders name: _____ DOB_____ Gender M F

Policy holders address (if different than the patients address)

_____

Policy holder' s insurance number: _____

Relationship of the policy holder to the patient: _____

_____ _____

Signature of patient or guardian Date

SIGNATURE ON FILE AUTHORIZATION

Statement to Permit Payment of Medicare or

Any Other Health Insurance Benefits to Supplier, Physician, or Patient

I request that payment of authorized Medicare or any other health insurance benefits be made either to me or on my behalf to above noted physician/supplier for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Patient Signature Date

AUTHORIZATION FOR TREATMENT & RESPONSIBILITY OF ACCOUNT

• I have provided the necessary medical information and I authorize treatment.

• I understand the charges on my account **ARE MY RESPONSIBILITY REGARDLESS** of insurance coverage and agree to make payments to keep the account current pending receipt of insurance monies.

IF MY INSURANCE IS AN HMO OR PPO, I understand I am responsible for my co-payment or the portion indicated by my carrier.

_____

Patient Signature /Date

_____

Parent/Guardian if patient under 18 years of age/date

NO SHOWS: There will be a fee of $25.00 for all appointments not canceled 24 hours prior unless you have an emergency that prevents you from attending your appointment. I have read and acknowledge the no show fee.

Patient Signature;_____Date:_____