

SIGNATURE DERMATOLOGY

Marya Cassandra, DO, FAOCD

Board Certified Dermatologist

Andrea Costanza, DO, FAOCD

Board Certified Dermatologist

New Patient Instructions

1. Please arrive 15 minutes early for your first appointment to allow time for the check-in process.
2. You may print and fill out the "Patient Registration Forms" in advance to save time. You will also be able to review our privacy policy upon arrival.
3. In addition, please bring to your visit:
 - a. Insurance Card(s)
 - b. Picture ID
 - c. If under 18, the patient must be accompanied by a parent/guardian
 - d. A method to paying your co-pay or any patient balance. We accept checks, Visa, Master Card, and Discover

PLEASE SEE THE FOLLOWING PAGES FOR PATIENT REGISTRATION

Thank you and we look forward to seeing you!

SIGNATURE DERMATOLOGY

(614) 777-1200

Patient's Name

First

Middle

Last

Address

Street &

Apt #

City

State

Zip

Birthdate _____ Soc. Sec. # _____ Female Male

Home # _____ Cell # _____ Work # _____

Do you give our office permission to discuss your medical information with family members:

Yes No If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (____) _____ Phone # (evening): (____) _____

May we leave personal medical information on your answering machine or cell phone? Yes No

May we e-mail personal medical information to you? Yes No E-mail Address _____

Please list any other contact persons that we may discuss results or answer questions

Name: _____ Phone #: _____

Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____

If Patient is a Minor, Please Enter Insured Guardian or Parent Information Here

Name _____

First

Middle

Last

Birthdate _____ Social Security # _____

Relationship to Patient _____ Employer _____

Primary Care Physician _____

Emergency Contact

(Not in your household) _____ Phone # _____

Relationship to Patient _____

I understand that office visit charges are payable on the day service is rendered. I authorize Signature Dermatology, LLC to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Signature Dermatology, LLC and myself.

Signature _____ Date _____

SIGNATURE DERMATOLOGY

Medical History Form

Name : _____

Current Medications (dosage **NOT** necessary): _____

Allergies : _____

PERSONAL HISTORY

| | | | |
|---------------------------------|----|-----|-----------------------|
| Asthma | NO | YES | |
| Cancer (non-skin related) | NO | YES | Type of Cancer : |
| Diabetes | NO | YES | |
| Eczema | NO | YES | |
| Hepatitis | NO | YES | Type of Hepatitis : |
| High Blood Pressure | NO | YES | |
| HIV | NO | YES | |
| Hives | NO | YES | |
| Lupus/Connective Tissue Disease | NO | YES | |
| Pacemaker/Defibrillator | NO | YES | |
| Psoriasis | NO | YES | |
| Skin Cancer | NO | YES | Type of SKIN cancer : |
| Stroke | NO | YES | |
| Thyroid Disorder | NO | YES | |
| Tuberculosis | NO | YES | |
| Other Medical Problems | NO | YES | List: |
| | | | |
| | | | |

| FAMILY HISTORY | Family Member(s) | Details |
|-----------------------|-------------------------|----------------|
| Skin Cancer | | |
| Skin Disease | | |

FEMALE PATIENTS : Are you pregnant and/or breastfeeding? YES NO

Social History (please check) :

ALCOHOL

| | |
|--------------------------|----------------|
| <input type="checkbox"/> | NO |
| <input type="checkbox"/> | YES – Daily |
| <input type="checkbox"/> | YES – Socially |

TOBACCO

| | |
|--------------------------|---------------|
| <input type="checkbox"/> | NO |
| <input type="checkbox"/> | YES – Smoking |
| <input type="checkbox"/> | YES – Chewing |

TANNING

| | |
|--------------------------|-------------------|
| <input type="checkbox"/> | NO |
| <input type="checkbox"/> | YES – Sunbathe |
| <input type="checkbox"/> | YES – Tanning Bed |



SIGNATURE DERMATOLOGY

Marya Cassandra, DO, FAOCD

Board Certified Dermatologist

Andrea Costanza, DO, FAOCD

Board Certified Dermatologist

Assignment of Benefits and HIPAA Notice

I authorized direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Signature Dermatology, "SD" for all covered medical services and supplies provided to me during all courses of treatment and care provided by SD.

I understand that I am financially responsible to SD for any charges not covered by health care benefits. It is my responsibility to notify SD of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by SD and/or my health care insurer if the submitted claims or any part of them are denied for payment. For patient balances, if I do not have a payment plan in place 30 days after the bill date, there will be a **\$10 FEE** every month the balance is unpaid. I understand that by signing this form that I am accepting financial responsibility as explained above for all payments for medical services and/or supplies received. If I cannot make a scheduled appointment I will notify within 24 hours of the appointment. Otherwise I am aware SD will charge me a **\$25 FEE** for the doctor's lost time.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by SD.

By signing this document, I also acknowledge that I have been given the opportunity to read SD's laminated Notice of Privacy Practice. I can also receive a copy of this form by making a request at any time. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of Person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____