SIGNATURE DERMATOLOGY (614) 777-1200

**Patient’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

 Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Apt # City State Zip

Male

Female

 Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single

**Marital Status**:

**Patient’s Employer**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** (*not in your household*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

No

Yes

 If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone # (day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (evening) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May we leave personal medical information on your answering machine or cell phone?**

Yes

No

Yes

No

**May we e-mail personal medical information to you?**  E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please include PRIMARY INSURED PERSON, Guardian or Parent Information Here:**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

 **Birthdate** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that office visit charges are payable on the day the 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 and myself.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Assignment of Benefits and HIPAA Notice**

I authorize 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 my 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. All patient balances are due upon receipt. If I have not paid the balance in full, or a payment plan is not in place 30 days after the bill date, there will be a **$10 LATE FEE** every month the balance is unpaid. I understand that by signing this form, I am accepting financial responsibility as explained above for all payments regarding medical services and/or supplies received. If I cannot make a scheduled appointment I will notify SD within 24 hours of the appointment. Otherwise, I am aware SD will charge me a **$25 FEE** for the lost appointment time of which another patient would have benefited. SD offers an on-call service for dermatology related emergencies. All non-emergency calls will be charged a **$25 FEE**.

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 located in the front lobby. 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:

**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 or breastfeeding? YES NO**

**Social History (please check):**

 **ALCOHOL TANNING SMOKING**

|  |  |
| --- | --- |
|  | NO |
|  | YES – Daily |
|  | YES – Socially |

|  |  |
| --- | --- |
|  | NO  |
|   | YES – Sunbathe |
|  | YES – Tanning Bed |

|  |  |
| --- | --- |
|  | NO |
|  | Former Smoker |
|  | Current Smoker |