Patient Medical Form

IDEAL DERMATOLOGY/ SKIN PC

Personal Identification

First:_____ Middle_____ Last:_____

Phone #:_____ Date of Birth: _____ Gender: _____

Last 4 of SS#:_____ Pharmacy:_____

Primary Care: _____ Email:_____

Section I: Past Medical History (Please circle ALL that may apply and add any not listed)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Melanoma
Bone Marrow Transplant	Hearing Loss	Melanoma-Family History
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood Pressure	Skin Cancer (Other)
COPD	High Cholesterol	Stroke
Coronary Artery Disease	HIV/AIDS	***NONE***

List all major surgeries:

_____

Do you require antibiotics prior to a surgical procedure? YES NO

Section IV: Social History

1. Are you a current or past smoker? No Yes
2. If yes, how much? _____

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? [ ] No [ ] Yes, please list:

Name _____ Reason _____

Name _____ Reason _____

Name _____ Reason _____

Name _____ Reason _____

Name _____ Reason _____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

Section VII: Alerts: (Please circle ALL that may apply and add any not listed)

Allergy to Adhesive	Artificial Heart Valve	Defibrillator
Allergy to Lidocaine	Artificial Joint Replacement	MRSA
Allergy to Topical Antibiotics	Blood Thinners	Pacemaker
		NONE

Do you have a rapid heart beat with epinephrine? YES NO

Are you pregnant or currently trying to get pregnant? YES NO

Emergency Contact: Name:_____ Phone Number:_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge

Patient Signature:_____ **Date:** _____

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Patient HIPAA Acknowledgement and Consent Form

Patient Name _____ **Date of Birth** _____
(please print FULL legal name)

_____ (Patient initials) I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures.

_____ (Patient initials) I agree that the practice may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ (Patient initials) The practice may leave a detailed phone message at the following listed numbers regarding my medical or billing information. (____) _____ (____) _____

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of billing and payment, communicating results, findings, and care decisions to the people designated below. Information will not be released without authorization, even to family members.

	Name	Relationship	Contact Number
1.	_____	_____	(____) _____
2.	_____	_____	(____) _____
3.	_____	_____	(____) _____

I certify that I have read and fully understand all of the above statements and consent fully and voluntarily to all included statement.

Print Patient or Responsible Party Name: _____ **Date:** _____

Patient or Responsible Party Signature: _____ **Date:** _____

Relationship to Patient: _____

This consent will remain in effect and grants permission for one year from the time of signing. Permissions may be revoked in writing prior to the expiration.

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Receipt of Financial Responsibility Policy

I have been offered a copy, read, understand and agree to the provisions of this Financial Responsibility Policy Form and agree to pay Ideal Dermatology/Skin PC promptly all amounts for which I am responsible under this form.
I agree that I am financially responsible for payment in full of all charges incurred regardless of insurance coverage (to the extent permitted by applicable law). I am aware that my insurance company may deny payment or make partial payment and I agree that I will be responsible for the balance due (to the extent permitted by applicable law). I am aware that it is my responsibility to contact my insurance company to verify that it will pay for charges incurred.

Signature of Patient or Guardian _____ Date _____

Print Name _____ Patient Name (if different) _____

Please initial the following statement(s) if it applies to your visit today:

_____ ***I hereby acknowledge that I do not have or do not wish to provide my health insurance for claim. Therefore, Ideal Dermatology/Skin PC will bill me directly as a SELF PAY patient for all services rendered.***

_____ ***I hereby acknowledge that I have not brought proof of medical insurance or a referral (if needed) with me to my appointment today and understand my network benefits cannot be verified at time of service. If it is later determined Ideal Dermatology/Skin PC is out of my network, I understand I will be billed directly as a SELF PAY patient for services rendered.***

Assignment and Release

1. I have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered.
2. I understand that I am financially responsible for all charges whether or not paid by insurance.
3. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
4. I authorize the use of this signature on my insurance submissions.
5. **Pathology Billing Information:** I understand my current charges DO NOT include my charges for any pathology/lab service completed at my medical appointment today. Pathology results will be made available within 7-10 business days of service.

Signature of Patient or Guardian _____ Date _____