Patient Demographics and Insurance Information

Last Name: _____ First Name: _____ MI:_____

DOB:_____ _____ SSN: _____

Address: _____ City:_____ State: ____ Zip: _____

PH: (Home)_____ (Cell) _____ (Work)_____

Email: _____ *(for Patient Portal and Appt Reminders only)*

Emergency Contact Name: _____

Emergency Contact Phone: _____

Primary Care Physician: _____

RESPONSIBLE PARTY INFORMATION (If Patient is under 18 years of age, please complete this section)

Responsible Party Name: _____

Responsible Address: _____

Responsible Party Phone: _____

PRIMARY INSURANCE CARRIER AND POLICY INFORMATION

Primary Insurance: _____ Policy #: _____

Does your insurance policy require a **Referral** from your Primary Doctor to see a Specialist?

_____ (Yes)
_____ (No)

If (Yes), please contact your primary care physician and request that a **Referral** be sent to O'Fallon Dermatology Specialists at least 2 Days prior to your office visit.

Note: If you are unsure of your need for a Referral, please contact your insurance carrier and/or primary care physician for this information.

SECONDARY INSURANCE CARRIER AND POLICY INFORMATION

Primary Insurance: _____ Policy #: _____

Signature of Patient or Legal Representative/Custodian

Signature:_____ Date: _____

NAME: _____ DATE OF BIRTH: _____

Past Medical History: (please check all that apply…or check NONE)

_____Anxiety
_____Arthritis
_____Asthma
_____Atrial fibrillation
_____BPH (enlarged prostate)
_____Bone marrow transplant
_____Breast cancer
_____Colon cancer
_____COPD/Emphysema
_____Coronary artery (heart) disease
_____Depression
_____Diabetes
_____End stage kidney disease
_____GERD (acid reflux)
_____Hearing loss
_____Hepatitis
_____High cholesterol
_____HIV/AIDS
_____Hypertension – high blood pressure
_____Hyperthyroidism
_____Hypothyroidism
_____Leukemia
_____Lung cancer
_____Lymphoma
_____Prostate cancer
_____Radiation treatment
_____Seizures
_____Stroke
_____NONE of the above

Other Medical History:
_____

Surgical History – over the past 1 year only
_____

_____

Skin Cancer History: (please check all that apply…or check NONE)

_____Actinic keratosis (pre-cancers)
_____Basal cell skin cancer
_____Melanoma
_____Squamous cell skin cancer
_____NONE

Other Skin Disease: _____

Do you wear sunscreen? _____Yes _____No
Do you use a tanning bed? _____Yes _____No
Family history of melanoma? _____Yes _____No

If yes, which relative(s): _____

Family history of non-melanoma skin cancer (basal cell carcinoma or squamous cell carcinoma)? _____Yes _____No

If yes, which relative(s): _____

Medications: (please list all current medications…or check NONE) _____ NONE
_____

_____

_____

_____

Allergies: (please list all medication allergies…or check NONE) _____ NONE
_____

_____

NAME: _____ DATE OF BIRTH: _____

Social History: (please check one in each category)

Alcohol Use:
_____None
_____Less than 1 drink per day
_____1-2 drinks per day
_____More than 3 drinks per day

Smoking:
_____Never smoked
_____Quit – former smoker
_____Still smoke daily
_____Still smoke less than daily

List your occupation or retired or student: _____

Race:
_____White
_____Am Indian/Alaska Native
_____Asian
_____Black/African American
_____Decline to Specify

Preferred Language:
_____English
_____Spanish
_____Decline to Specify
Other_____

Ethnicity:
_____Hispanic/Latino
_____Non-Hispanic/Other
_____Decline to Specify

Pharmacy: Name, Location, and Zip Code:_____

Primary Care Physician: _____

Review of Systems: (please check yes or no in response to each)

Fever or chills	_____ Yes	_____No
Cold or flu or sore throat	_____ Yes	_____No
Chest pain	_____ Yes	_____No
Breathing problems – shortness of breath, cough	_____ Yes	_____No
Stomach problems – nausea, vomiting, diarrhea	_____ Yes	_____No
Any healing, scarring, or bleeding concerns	_____ Yes	_____No

Medical Alerts: (please check yes or no in response to each)

Allergy to adhesives	_____ Yes	_____No	Need antibiotic prior to surgery	_____ Yes	_____No
Allergy to lidocaine	_____ Yes	_____No	Allergy to topical antibiotics	_____ Yes	_____No
Blood thinners	_____ Yes	_____No	Pacemaker or defibrillator	_____ Yes	_____No

Chief Complaint: Give the primary reason you are here today. **Please prioritize and list no more than two complaints**. To respect other patient appointment times, a second visit will need to be made to address any additional concerns.

_____

_____

_____

_____ _____
Patient or Guardian Signature Date

_____ _____
Physician Assistant Signature Date

_____ _____
Dermatologist Signature Date

NAME: _____ CHART NUMBER: _____

DATE OF BIRTH: _____

EMAIL:_____ *(Used for Patient Portal access and Appt Reminders only)*

Consent to Use and Disclose Medical Information (HIPAA)

_____ I understand that as part of my healthcare, O'Fallon Dermatology Specialists creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the health professionals who care for me, a source of information for applying my diagnosis and treatment information to my bill, and a means by which my bills can be submitted to and paid by a third party payer.

O'Fallon Dermatology Specialists has a published *Privacy Practices Policy* that provides a more complete description of information uses and disclosures. I have the right to review the full policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and will mail a copy of any revised notice to the address I've provided upon my request. I have the right to request restrictions as to how my health information may be used or disclosed and to whom it may be disclosed, other than for purposes of communication among health professionals and submission and payment from third party payers. I agree to allow my care provider to access my pharmacy medication records electronically as needed to manage my health care. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I agree that O'Fallon Dermatology Specialists may use the following forms of communication to relay a message to me regarding my medical information: telephone messages at the phone number(s) I have provided, written communication via mail service to the address I have provided, and email message to the email address I have provided. By supplying phone numbers, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication.

I give Dr. Angela Spray and the staff of O'Fallon Dermatology Specialists permission to discuss my medical information with the following people: (Please list names, phone numbers, and relationships)

_____

_____

Permission to Bill Insurance and Notice of Office Policies

_____ I authorize O'Fallon Dermatology Specialists to release to Medicare or my insurance carrier any information needed to process my insurance claims. I permit this authorization to be used to request payment of medical insurance benefits to O'Fallon Dermatology Specialists.

_____ I have been informed of O'Fallon Dermatology Specialist's office policies:

1. I understand that I must present a valid driver's license or a photo I.D. and a current insurance card at every office visit. I agree that all co-pays and prior account balances will be paid prior to seeing the providers.

2. Once my insurance company has paid its portion of the office charges, I am aware that I will receive a statement for any charges that are my responsibility. I understand that payment for these charges are due at the time the statement is received and that I will be charged a $10 late fee every month for any charges that are not paid before the next billing statement. I know that O'Fallon Dermatology Specialists will not provide me with a payment plan but that the company does accept MasterCard or Visa. I have been informed that if I fail to pay my account in full within 60 days of the first statement, it will be turned over to professional collections and I will be charged a fee of $20 for this collection service. I understand that there is a $25 fee for all returned checks.

3. I agree that I will give 24 hours advance notice of an appointment cancellation and that I will be charged a $50.00 no-show fee if I fail to provide such notice of cancellation as stated.

Signature of Patient or Legal Representative/Custodian

Signature:_____ Date: _____