



# ADVANCED DERMATOLOGY & SKIN CANCER CENTER

**Patient Information**  New Patient  Name Change  Address Change  Insurance Change  
**THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:** Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.

Mailing Address \_\_\_\_\_  
City State Zip

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ E-mail: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_/Sex:  Male  Female/ Social Security # \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Other Employment Status:  Working  Retired  Disabled  Unemployed  
 Student  Full Time  Part Time

Employer Name \_\_\_\_\_ Employer \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (if different from patient) RELATIONSHIP \_\_\_\_\_**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
City State Zip Code

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

How did you hear about our practice?  Yellow pages  Newspaper  Friend/Patient  Other \_\_\_\_\_

**INSURANCE INFORMATION**

Do you have health insurance? \_\_\_\_ YES \_\_\_\_ NO

Guarantor is the person whose NAME is on the insurance card.

Primary Insurance Company \_\_\_\_\_ Secondary Insurance Company \_\_\_\_\_

Insurance ID number \_\_\_\_\_ Insurance ID number \_\_\_\_\_

Insurance Group number \_\_\_\_\_ Insurance Group number \_\_\_\_\_

Name of Guarantor \_\_\_\_\_ Name of Guarantor \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Guarantor Social Security Number \_\_\_\_\_ Guarantor Social Security Number \_\_\_\_\_

Guarantor Date of Birth \_\_\_\_\_ Guarantor Date of Birth \_\_\_\_\_

PHARMACY OF CHOICE \_\_\_\_\_  
NAME ADDRESS

**Please present your insurance card(s) and a photo ID to the receptionist along with this completed form.**



**PLEASE READ THE FOLLOWING CAREFULLY AND SIGN UPON COMPLETION. If you have any questions, please don't hesitate to ask the staff for clarification.**

Advanced Dermatology & Skin Care Center is required to keep your signature on file authorizing us to file claims to Insurance for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

***I understand I am FULLY responsible for all charges whether or not paid by insurance or if no insurance is available. I understand if charges I am responsible for are not paid in a timely manner and are sent for outside collection I will be responsible for any collection fee in addition to the balance turned to said outside collection agency.***

***I understand my insurance MAY cover ALL charges and I may not receive a statement for charges other than my co-pay and/or deductible as determined by my individual insurance plan.***

*I authorize any holder of medical or other information about me to release to my Insurance Company, or its intermediaries or carrier, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Insurance assignment of benefits apply.*

\_\_\_\_\_  
Signature

\_\_\_/\_\_\_/\_\_\_  
Date

If you have a supplemental policy and it is a secondary policy to which your Insurance automatically "crosses over", we are required to keep a separate signature on file:

*I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.*

\_\_\_\_\_  
Signature

\_\_\_/\_\_\_/\_\_\_  
Date

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

YES  NO If yes, please provide their name and phone number.

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

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

Phone # (day): (\_\_\_\_) \_\_\_\_\_

Evening #: (\_\_\_\_) \_\_\_\_\_

**May we leave personal medical information on your answering machine at home?**  YES  NO

**May we e-mail personal medical information to you?**  YES  NO

E-mail address: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_



## HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also consent to the taking of any photographs by the staff to be become a part of my medical records; to be shared with any referring physicians; to be used in research projects; and as deemed necessary by Advanced Dermatology & Skin Cancer Center.

### The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations  
The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice  
The Practice reserves the right to change the Notice of Privacy Practices  
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions  
The patient may revoke this Consent in writing at any time and all future disclosures will then cease  
The Practice may condition receipt of treatment upon the execution of this Consent.

### This Consent was signed by:

\_\_\_\_\_  
Printed Name – Patient or Representative

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Relationship to Patient  
(if other than patient):

\_\_\_\_\_

### Witness:

\_\_\_\_\_  
Printed Name – Practice Representative

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**MEDICAL HISTORY**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

What is the primary reason for your visit today? \_\_\_\_\_

Have you ever had skin cancer before? If yes, what type? \_\_\_\_\_

Female Patients – Are you currently pregnant? Yes No Date of Last Menstrual Cycle: \_\_\_\_\_

**DRUG ALLERGIES**

Name of Drug \_\_\_\_\_ Type of reaction (rash, hives, nausea, etc.) \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**CURRENT MEDICAL PROBLEMS**

(high blood pressure, diabetes, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**CURRENT MEDICATIONS**

Medication Name \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**PLEASE LIST ANY PAST SURGICAL PROCEDURES**

Surgery Hospital/Location \_\_\_\_\_ Date \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**FAMILY HISTORY**

Is there a family history of skin cancer? If so, what type? Yes No Type \_\_\_\_\_

Is there a family history of any skin disorder? If so, what kind? Yes No Type \_\_\_\_\_

Is there any other important family medical history? Yes No List \_\_\_\_\_

Do you need to take antibiotics prior to having your teeth cleaned? Yes No

Do you need help with walking? Yes No

Do you smoke? Yes No # packs per day \_\_\_\_\_ How many years have you smoked \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how much & how often \_\_\_\_\_

**REVIEW OF SYSTEMS – PLEASE CIRCLE THE PROBLEMS YOU HAVE HAD IN THE LAST FEW WEEKS OR CURRENTLY HAVE**

Angina	Double Vision	Indigestion/Reflux	Painful Bowel Movements
Arthritis	Difficulty Hearing	Incontinence	Paralysis
Abnormal Wound Healing	Depression	Inability to Urinate	Prolonged Bleeding
Bloody Bowel Movements	Diarrhea	Joint Pains / Joint Swelling	Reproductive /Menstrual Cycle
Chills	Difficulty Sleeping	Loss of Consciousness	Skin Growths
Changes in vision	Ear Pain	Muscle Pains	Shortness of Breath
Chronic Rashes	Fevers	Night Sweats	Seizures
Chest Pains	Fainting	Numbness	Ulcers
Cough	Headache	Nausea	Vomiting
Dizziness or Fainting	Heart Palpitations	Painful Urination	Weight Loss

**PAST MEDICAL HISTORY – PLEASE CIRCLE THE PROBLEMS YOU HAVE HAD**

Arthritis	Gastric Ulcer	Hearing Impairment	Psychiatric Condition
Anemia	Gonorrhea	Kidney Problems	Rheumatic Fever
Artificial Heart Valve	Gastrointestinal Disorder	Keloids	Sexual/Menstrual Dysfunction
Artificial Joints	HIV/AIDS	Lupus	Syphilis
Asthma	High Blood Pressure	Lyme Disease	Scarlet Fever
Bleeding Disorder	Heart Disease	Mitral Valve Prolapse	Seizures
Diabetes	Heart Attack	Nerve Damage	Stroke
Emphysema	Heart Failure	Osteoporosis	Thyroid Abnormality
Allergies (seasonal)	Heart Surgery	Pacemaker / Defibrillator	Tuberculosis
Glaucoma	Heart Murmur	Pneumonia	Vascular Disease
Gallbladder Disease	Hepatitis	Prostate Problems	Visual Impairment

Do you have any disease, condition or problem not listed? If so, please describe below.  
\_\_\_\_\_

Doctors Signature \_\_\_\_\_

Date \_\_\_\_\_