

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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End stage kidney disease | <input type="checkbox"/> Lung cancer |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> GERD (acid reflux) | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> BPH (enlarged prostate) | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Bone marrow transplant | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Hypertension – high blood pressure | <input type="checkbox"/> NONE of the above |
| <input type="checkbox"/> Coronary artery (heart) disease | <input type="checkbox"/> Hyperthyroidism | |

Other Medical History: _____

Surgical History – over the past 1 year only

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

- | | | |
|--|--|-------------------------------|
| <input type="checkbox"/> Actinic keratosis (pre-cancers) | <input type="checkbox"/> Melanoma | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Basal cell skin cancer | <input type="checkbox"/> Squamous cell skin cancer | |

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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold or flu or sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breathing problems – shortness of breath, cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stomach problems – nausea, vomiting, diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any healing, scarring, or bleeding concerns | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- | | | | | | |
|----------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|-----------------------------|
| Allergy to adhesives | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Need antibiotic prior to surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy to lidocaine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergy to topical antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood thinners | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker or defibrillator | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: _____