SOUTH COUNTY DERMATOLOGY

PATIENT INFORMATION FORM

APPOINTMENT DATE & TIME_____

Name _____Nickname_____

Address: _____
STREET CITY STATE ZIP

Phone: _____
HOME CELL WORK

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Email: _____@_____

Do you wish to receive email/text message reminders? ☐YES ☐NO

Primary Care Physician: _____Phone: _____Last visit_____

Referring Physician (If not same as above): _____

PRIMARY Insurance Information:

_____
Insurance Name/Type Policy Holder's Name/DOB Relationship to Patient

_____
Insurance Number Policy Holder's Address (if different from above)

SECONDARY Insurance Information (if applicable):

_____
Insurance Name/Type Policy Holder's Name/DOB Relationship to Patient

_____
Insurance Number Policy Holder's Address (if different from above)

• Robert K. Dyer, MD • Vincent D. Criscione, MD •
• Kathryn Sliney, PA-C • Meighan Dingle Blanco, FNP-BC • Lauren Vieira, PA-C
• Nancy Staley, PA-C • Jennifer Johnson, APRN • Lauren Volpe PA-C

3461 South County Trail, Suite 202 East Greenwich, RI 02818 •
350 Kingstown Road, Suite 202, Narragansett, RI 02882
268 Post Road, Suite 201, Westerly, RI 02891 • 338B County Road Barrington, RI 02806
401-471-DERM (3376) • 401-471-6865 (fax) • **www.southcountyriderm.com**

MEDICAL HISTORY FORM

NAME: _____ DATE OF VISIT: _____

Past/Present Medical History: (please circle all that apply)

Anemia	Dementia	Lung Cancer
Anxiety	Depression	Lymphoma
Arthritis	Diabetes	Pacemaker
Asthma	End Stage Renal Dis.	Prostate Cancer
Atrial fibrillation	Acid Reflux -GERD	Radiation Treatment
BPH-Enlarged Prostate	Hearing Loss	Seizures
Bone Marrow Transplt.	Hepatitis - A/B/C	Stroke
Breast Cancer	High Blood Pressure	Thyroid Disease:
Colon Cancer	High Cholesterol	Hyperthyroid
COPD	HIV/AIDS	Hypothyroid
Coronary Artery Dis.	Leukemia	Valve Replacement

Other _____

Past Surgical History: (please circle all that apply)

Appendix removed	Joint Replacement within last 2 years
Bladder surgery	Kidney Biopsy
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: Inflammatory Bowel Dis.	Prostate Biopsy
Gallbladder Removed	Prostate – TURP
Coronary Artery Bypass	Skin Biopsy_(Year)_____
Heart Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral) Year_____	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral) Year_____	Hysterectomy: Cancer

Other _____

Current Skin Problems: What is the primary reason for your visit?

☐Full Skin Exam ☐Rash ☐Changing Mole ☐Acne ☐Psoriasis ☐Warts ☐Cosmetic Consult
☐Other_____

Skin Disease History: (please circle all that apply)

Acne	Eczema	Precancerous Moles
Actinic Keratoses	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Rosacea
Blistering Sunburns	Melanoma	Squamous Cell Skin Ca
Dry Skin	Poison Ivy	Warts

Other _____
Do you wear Sunscreen? YES NO If YES, what SPF? _____
Do you tan in a tanning salon? YES NO
Do you have a family history of Melanoma? NO__ YES (which relative)_____

Pharmacy_____
Address_____**Phone**_____

Medications: (Please list all current medications or attach a copy)

_____ _____
_____ _____
_____ _____
_____ _____

Allergies: (Please list all Allergies to Medications, Food, Environmental, etc...)

_____ _____
_____ _____

Surrogate (Someone we could call regarding your Health Care/Next of Kin):
Name_____Relationship_____Phone_____

Social History:
☐Never Smoked ☐Former Smoker ☐Current Every Day Smoker ☐ Occassional Smoker
Have you had your FLU SHOT this year? Yes____No____
Have you ever had a Pneumonia Shot? Yes____No_____

Responses to the next two questions are at the request of the Federal Government.
1. **Race** ☐Caucasian ☐African American ☐American Indian ☐Asian ☐Other _____
2. **Ethnic Group** ☐Hispanic or Latino ☐Not Hispanic or Latino

We would like to know a little more about you:

Occupation:_____Employer:_____

How did you hear about us? _____

Other family members who are patients: _____

Hobbies/Interests _____

Page 3 of 3 **Review of Systems**:

Please check YES or NO to each of the following as they apply to you at TODAY'S VISIT

SYMPTOM	YES	NO
Problems with Bleeding		
Problems with Healing		
Problems with Scarring (Keloid)		
Immunosuppression		
Changing Mole		
Rash		
Abdominal pain		
Anxiety		
Bloody Stool or Bloody Urine		
Blurry Vision		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Pacemaker or Defibrillator		
Artificial Heart Valve		
Artificial Joints – (hip, knee) within the past 2 years		
Antibiotics needed prior to dental procedures? (Prophyllaxis)		
Allergy to Adhesive (Tape, Band-Aids)		
Allergy to Antibiotic Ointments (Neosporin, Bacitracin)		
Blood Thinners (Aspirin, Coumadin/Warfarin, Plavix)		
Pregnant or Planning Pregnancy		
Allergy to Lidocaine		
Rapid heartbeat with Epinephrine		
Yeast Infection with Antibiotics		
GI upset with Antibiotics (Nausea, Diarrhea)		

Other Symptoms:

_____

HIPAA PATIENT CONSENT

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 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 your treatment, payment, and health care operations. You have the right to revoke this Consent; in writing, signed by you. Such a revocation, however, 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)

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 an opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practice's.
- The patient has the right to restrict the use of his/her information but the Practice does not have to agree to those restrictions if, for example, they interfere with our ability to provide quality health care, payment, or daily operations.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Name Printed_____Date_____

Signature_____

Authorized Representitive_____Relationship_____

Witness (Practice Representitive)_____

FINANCIAL POLICY

GENERAL POLICY

Our Goal is to clearly communicate our policies to our patients. If you have any questions regarding these policies, please feel free to speak with Dr. Dyer.

Payment for services is due in full at the time service is provided. We accept, Checks, Cash, most major Credit Cards (No American Express) and Health Savings Cards. We are happy to arrange a payment plan with the patient, including pre-authorized charges to a credit card at the patient's discretion.

PATIENTS WITH PRIVATE INSURANCE PLANS AND/OR MEDICARE

We accept most major insurance plans and will submit a bill to the patient's primary insurance carrier. We also will bill most secondary insurances companies for the patient. Co-Payments and Deductibles, to the extent that they can be determined, are due at the time of service. It is often the case that copays and deductibles will not be known until after we submit the claim to an insurance company. In those cases, we will bill the patient for the balance and payment will be due within thirty days.

If a referral and/or prior authorization for either a visit or a procedure is necessary under a particular insurance plan, obtaining the referral or authorization is the patient's responsibility.

COSMETIC SERVICES

Generally, Cosmetic services are not covered by insurances; thus, payment is expected at the time of service. In rare instances, we may attempt to collect payment from a patient's insurance company for a certain service or procedure that, in our opinion, is medically necessary but the company may determine to be of a cosmetic nature. In those situations, it is ultimately the patient's responsibility to pay for the service or procedure, and we will bill the patient.

I have read and understand the information on this Form and I agree to adhere to the Policies of South County Dermatology.

Name
Printed_____Date_____

Signature_____