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:

_____
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):

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

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

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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 Transplant	Hepatitis - A/B/C	Stroke
Breast Cancer	High Blood Pressure	Thyroid Disease:
Colon Cancer	High Cholesterol	Hyperthyroid
COPD	HIV/AIDS	Hypothyroid
Coronary Artery Disease	Leukemia	Valve Replacement

Other _____

Past Surgical History: (please circle all that apply)

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

 Review of Systems:

Please check YES or NO to each of the following as they apply to you for 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. (Prophylaxis)		
Allergy to Adhesive (Tape, Band-Aids)		
Allergy to Antibiotic Ointments (Neosporin, Bacitracin)		
Blood Thinners (Aspirin, Coumadin/Warfarin, Plavix,Eliquis,Xarelto)		
Pregnant, Planning Pregnancy, Nursing Mother		
Allergy to Lidocaine		
Rapid heartbeat with Epinephrine		
Yeast Infection with Antibiotics		
GI upset with Antibiotics (Nausea, Diarrhea)		

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 insurance; 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_____

South County Dermatology

Patient Privacy Practices Acknowledgment and Consent Form

Notice of Privacy Practices

We are committed to maintaining the privacy of your protected healthcare information. Pursuant to the Federal Health Insurance Portability and Accountability Act (HIPAA), South County Dermatology's Privacy Notice outlines how HIPAA permits us to use and disclose your protected health information (PHI); it also describes your rights under HIPAA, and it states that we have an obligation to protect the privacy of your health information.

Importantly, our Privacy Notice describes how we use and disclose PHI:

- to provide you with medical treatment and ensure the quality of your care
- to bill and collect payment for services; and,
- to support the operations of our Practice.

We encourage new patients to review our **Privacy Notice,** which is available upon request from our helpful staff upon check-in and via our website.

Acknowledgement and Consent

By signing below, I acknowledge that I have reviewed the **Privacy Notice** or that I have been provided with the opportunity to review it. I understand that the Notice may change and that I will have an opportunity to inquire about and review any revised Notice by contacting South County Dermatology.

I give my consent for South County Dermatology to use and disclose PHI about me to provide me with medical treatment, to process payment, and to support the Practice's operations. I may revoke consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

Patient Name (print)_____Date:_____

Patient Signature (if age 18 or older) _____

Parent/Guardian (if patient is under 18) Signature:_____

Patient's Representative (if applicable) Name and Signature: _____

_____Relationship to Patient:_____