PATIENT ACCOUNT NUMBER

Phys:	
Rec'd by:	

PATIENT INFORMATION (Please Print) **Today's Date** ____/____/____

Name_____
Last First M.I.

Address_____
Street Apt # City State Zip

Home Phone (___)_____ **Cell Phone** (___)_____ Work Phone (___)_____

Email Address_____ S.S. #_____

Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Date of Birth _____/_____/_____ Age_____ Sex_____

Employer_____ Address_____

Accompanying Parent (if minor) _____

SUBSCRIBER INFORMATION

Name_____
Last First M.I.

Address_____
City State Zip

Home Phone (___)_____ **Cell Phone** (___)_____ Work Phone (___)_____
Employer_____ Address_____

Date of Birth _____/_____/_____ Sex_____ S.S.#_____

INSURANCE INFORMATION (Please present insurance card at time of check-in.)

Primary Insurance Name _____
Ins. Address _____
Policyholder _____
Insured's ID# _____ Grp #_____
SS #_____ Date of Birth____/____/____
Relationship of patient to the Insured _____
Insured Employer Name _____
Insured Employer Address _____
Insured Employer Phone (____)_____

Secondary Insurance Name_____
Ins. Address _____
Policyholder _____
Insured's ID# _____ Grp #_____
SS #_____ Date of Birth____/____/____
Relationship of patient to the Insured_____
Insured Employer Name _____
Insured Employer Address _____
Insured Employer Phone (____)_____

PHARMACY of CHOICE _____ **PHONE** (____)_____
ADDRESS _____

Referring Doctor _____ **Family Doctor**_____
Address _____ Address _____
Phone _____ Phone _____

I authorize the release of medical information to my primary care or referring physician, to consultants, if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to physician.

In order to establish optimal relations with patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services **at the time they are rendered** unless you are in a prepaid plan in which we participate. For these patients, applicable copayments and deductibles will be collected **at the time of service**. We accept payment in the form of cash, check or credit card. **If your insurance plan denies payment, you will be responsible for payment to our office. In the event that your check is returned "insufficient funds" or your account must be turned over to collections, a $30.00 administrative fee will be added to your account.** Your signature below signifies your understanding and willingness to comply with this policy.

Signature / Guardian _____ **Date** _____/_____/_____

Chart # _____

MEDICAL INFORMATION

Patient Name _____ Date of Birth _____ Date _____

DESCRIBE CURRENT SKIN CONDITION _____

_____

PAST/FAMILY/SOCIAL HISTORY

1) Have you had skin cancer? NO___ YES___ WHERE/WHICH TYPE? _____

2) Do any family members have/had skin cancer? NO___ YES___ WHICH TYPE? _____

3) Have you recently been hospitalized or spent time visiting in a hospital? NO___YES ___ EXPLAIN _____

4) Do you wear sunscreen? NO___ YES___

5) Do you spend much time with your hands in water? NO___ YES___

6) Do any family members have the condition for which you are seeing us today? NO___ YES___WHO? _____

7) Do you or any family members have seasonal allergies or asthma? NO___ YES___ RELATIONSHIP _____

8) Do you work outdoors, spend a significant amount of time in the sun or use a tanning bed? NO___ YES___

9) Do you drink alcohol? NO___YES___ SOCIAL ___ EXPLAIN _____

10) Do you smoke? NO___ YES___ IF SO, HOW MUCH _____

11) Do you have an advanced directive? NO___ YES___

REVIEW OF SYSTEMS

___ Heart Problems	___ Thyroid Disease	___ Diabetes	___ H/O Drug or ETOH Dependency
___ Pacemaker/Defibrillator	___ Kidney Disease	___ Anemia	___ Hepatitis-type _____
___ High Blood Pressure	___ Venereal Disease	___ Seizures	___ Scar Easily
___ Heart Valve/Stent	___ Arthritis	___ Depression	___ Seasonal Allergies
___ High Cholesterol	___ Cold Sores	___ Anxiety	___ Emphysema
___ Easy Bleeding	___ Poor Healing	___ HIV/AIDS	___ Asthma
___ Lupus	___ Artificial Joints/Replacements- type and year _____		
___ Glaucoma	___ Currently Pregnant	___ Breastfeeding	

LIST OTHER CURRENT MEDICAL PROBLEMS: _____

_____

MEDICATION

Have you taken any **ASPIRIN, PLAVIX, COUMADIN, PERSANTINE, HEPARIN, MOTRIN, ADVIL, FISH OIL** or other pain relievers or Arthritis medications in the last TWO weeks? NO___ YES___ Please List: _____

Do you require premedication before surgical procedures? NO___ YES___

MEDICAL ALLERGIES AND REACTION: _____

_____

CURRENT MEDICATIONS (include OTC and Herbal): _____

_____

PHARMACY OF CHOICE:_____ PHONE #: _____ FAX# _____

REFERRING DR: _____ PHONE #: _____ FAX# _____

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI) The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Phone Number** – **Home** _____

Cell phone _____

Work phone _____

☐ Can leave detailed information
(**such as all medical/billing info**)

☐ Can leave limited information
(**such as benign/bloodwork results/billing info**)

☐ Leave call back number only

☐ **Written communication**

☐ E-mail _____

☐ Fax _____

☐ Home Address _____

_____

☐ Emergency Contact (if different from below):

_____

Other: _____

☐ **Persons authorized to receive information**

_____ Relationship _____ Phone _____

☐ **Medical** ☐ **Billing**

_____ Relationship _____ Phone _____

☐ **Medical** ☐ **Billing**

_____ Relationship _____ Phone _____

☐ **Medical** ☐ **Billing**

_____ _____ _____

Name Signature of Patient/Parent Date

ACKNOWLEDGEMENT OF RECEIPT OF
KUFLIK DERMATOLOGY CENTER
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received/read a copy of the Kuflik Dermatology Center Notice of Privacy Practices.

_____ _____ _____

Name Signature of Patient/Parent Date

Kuflik Dermatology Center Use Only
Date acknowledgement received: _____
-OR-

Reason acknowledgement was not obtained: _____