Dermatology 360

Patient Information

Name: ________________________

Date of Birth: __________________

Sex: __ Male __ Female

Address:____

City: __________________ State: __________________Zip code: ___________

Cell Phone: ___________________________Home phone:
____

Email Address: ________________________________

Primary care Physician: ___________________________________

Primary care Physician Phone Number: _____________________

Parent/Guardian Information (for minors only)

Name: ______________________________

Date of Birth: ___________________

I hereby authorize payment, directly to Dermatology 360 of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work and vaccines not covered by my insurance contract as performed in the office, and for any co-payment an/or deductible amount as specified in my insurance contract. I acknowledge that private health information material (HIPAA) is posted and available upon request.

________________________ ____________________________ ______________

Parent Name Signature Date

Name: ______________________ Date of Birth: _______________

Primary Insurance Information

Insurance company: ______________________________

Insured/card holder name: _______________________ date of birth: ____________

Relationship: ________________________ Phone Number: ______________________

Policy #: ___________________________________Group#: ______________________

Secondary Insurance Information

Insurance company: ______________________________

Insured/card holder name: _______________________ date of birth: ____________

Relationship: ________________________ Phone Number: ______________________

Policy #: ___________________________________Group#: ______________________

Pharmacy Information

Pharmacy Name: _____________________Phone Number: ______________________

Address: ____

Emergency Contact:

Name: ________________________________Phone: ______________________________

________________________________ __________________________ _______________

Name Signature Date

Financial Policy

Patient's Name________________________ DOB________________________

Please Initial Next to Each line.

_________ You are responsible for providing accurate information regarding your health insurance and for knowing your health insurance plan benefits. Prior to your visit today, our office has checked:

- Insurance is active
- Deductible and copay amounts for an office visit

_________If a procedure is preformed, you may be responsible for payment if it is not covered by your insurance. Please review all insurance correspondence.

_________ All insurance copays and deductibles must be paid at the time of service.

______________________________ ______________________

Patient signature Date

Medical History

Patient Name: ______________________________ Age: ___________

Occupation____

Why are you seeing the Doctor today_____________________________

____

How Long? ____

Past Treatments: ____

Current treatments: ____

Past Medical History:

Medical Problems: ____

List Current Medications: ______________________________________

Allergies: ____

List Prior Surgeries or hospitalizations and dates: _________________________

____

Family History:

Skin Cancer: Melanoma/basal cell/squamous cell Yes ____ No_____ family member__________

Abnormal moles: Yes_______ No________ Family Member____________________________

Eczema: Yes________ No__________ Family Member______________________________

Asthma Yes________ No__________ Family Member______________________________

Diabetes Yes________ No__________ Family Member______________________________

High Cholesterol Yes________ No__________ Family Member_________________________