DERMATOLOGY & MOHS SURGERY CENTER, PC

DEMOGRAPHIC INFORMATION

Patient Information:

Patient Name: DOB: Age:

Street Address: SSN:

Billing Address:

Home #: Cell #: Work#:

Email Address:

Employer: Occupation:

Hobbies/Interests:

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown Gender: Male Female Other

Race: White American Indian or Native American Asian Black or African American Native Hawaiian or Other Pacific Islander Other Race

Preferred Language: English Spanish Other:_____

Parent or Responsible Party:

Name: Relationship:

Mailing Address: DOB:

Home #: Cell #: Work #:

Emergency Contact Information:

Name: Relationship:

Mailing Address:

Home #: Cell #: Work #:

Pharmacy Information:

Pharmacy Name: Phone #:

Address:

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DEMOGRAPHIC INFORMATION

Primary Insurance Information:

Subscriber's Name: DOB:

Relationship to Patient: ____ Self ____Spouse/Partner ____ Child/Dependent

Insurance Carrier:

ID#: Group #:

Effective Date: Referral Required: Yes No

Employer:

Secondary Insurance Information:

Subscriber's Name: DOB:

Relationship to Patient: ____ Self ____Spouse/Partner ____ Child/Dependent

Insurance Carrier:

ID#: Group #:

Effective Date: Referral Required: Yes No

Employer:

Were you referred by another physician? Yes No

If yes, please provide the name of the referring provider: _____

Who is your Primary Care Physician (PCP)? _____

When was your last visit to your Primary Care Physician? _____

By signing, I attest that the information provided above is true and correct to the best of my knowledge.

Patient/Representative Signature: _____ Date: _____

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Medicare Patients: Our practice is a participating provider with Medicare. We will accept assignment on all claims. Patients are responsible for their yearly deductible and 20% portion of your bill not covered by Medicare. Our office is required to keep your signature on file authorizing us to file claims to Medicare on your behalf. By signing, you are authorizing Dermatology and Mohs Surgery Center, PC to release medical and/or other information to the Social Security Administration and Health Care financing Administration as needed for this or related Medicare claims. You are permitting the use of a copy of this authorization in place of the original and request payment of medical insurance benefits to either our practice or the party that accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Patient/Representative Signature: _____ Date: _____

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MEDICAL HISTORY

Patient Name: _____ **DOB:**_____

Past Medical History: (please circle all the apply)

Anxiety	Diabetes	Lymphoma
Arthritis	End Stage Renal Disease	Prostate Cancer
Asthma	Gastroesophageal Reflux Disease (GERD)	Radiation Treatment
Atrial Fibrillation (A-Fib)	Hearing Loss	Seizures
Bone Marrow Transplantation	Hepatitis	Pacemaker
Benign Prostatic Hyperplasia	High Blood Pressure	Other:
Breast Cancer	HIV/AIDS	
Colon Cancer	High Cholesterol	
Chronic Obstructive Pulmonary Disease (COPD)	Thyroid Problems (Hypo or Hyper)	**Women Only:**
Coronary Artery Disease	Leukemia	Pregnant: Y N Due:
Depression	Lung Cancer	Breastfeeding: Y N

Past Surgical History: (please circle all the apply)

Appendix Removed	Coronary Artery Bypass	Kidney Transplant
Bladder Removed	Mechanical Valve Replacement	Ovaries Removed: Endometriosis
Mastectomy (Left, Right, Bilateral)	Biologic Valve Replacement	Ovaries Removed: Cyst
Lumpectomy (Left, Right, Bilateral)	Heart Transplant	Ovaries Removed: Cancer
Breast Reduction	Knee Replacement (Left, Right, Bilateral)	Prostate Removed: Cancer
Breast Implants	Hip Replacement (Left, Right, Bilateral)	Prostate Biopsy
Colon Cancer Resection	Joint Replacement within last 2 years	Spleen Removal
Colectomy: IBD	Kidney Biopsy (Nephrectomy)	Testicles Removed (Right, Left, Bilateral)
Gallbladder Removed	Kidney Removed (Right, Left)	Hysterectomy: Fibroids
Cancer:	Kidney Stone Removal	Hysterectomy: Uterine Cancer
		Other:

Skin Disease History: (please circle all the apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses (Precancerous)	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Carcinoma	Hay Fever/Allergies	Squamous Cell Carcinoma
Blistering Sunburns	Melanoma	Other:

Family History: (please circle all the apply)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other
Non-melanoma Skin Cancer	Mother	Father	Sister	Brother	Daughter	Son	Other
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Other
High Cholesterol	Mother	Father	Sister	Brother	Daughter	Son	Other
High Blood Pressure	Mother	Father	Sister	Brother	Daughter	Son	Other
Other:	Mother	Father	Sister	Brother	Daughter	Son	Other

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MEDICAL HISTORY

Medications: (Please list all current medication including vitamins, OTC medications and herbal supplements)

***If you have a current list, please present to the receptionist to copy for your chart.**

Medication Name	Dosage	Frequency	Route
Example: Levothyroxine	*50mg*	*Once daily*	*Oral*

Are you allergic to any medications? Yes No If yes, please specify:

_____ _____ _____ _____

Do you require antibiotics prior to dental/surgical procedures?	Yes	No	
Do you wear sunscreen?	Yes	No	SPF:
Do you tan in a tanning salon?	Yes	No	

Social History: (Please check all that apply)

Cigarette Smoking:

___ Never Smoked ___ Quit: Former Smoker ___ Smokes Less Than Daily ___ Smokes Daily

Alcohol Consumption:

How often in the last 12 months have you consumed more than 5 drinks at one sitting?

___ Never ____ Once ____ Twice or more

**********For Patients 18 years of Age and Older**********

Is this your first visit to our practice?	Yes	No
Do you have an Advanced Care Plan (Advanced Directive/Living Will)?	Yes	No
If yes, did you bring a copy with you today?	Yes	No
Have you received you flu vaccination this year?	Yes	No
Have you received the pneumonia vaccine this year?	Yes	No

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Patient Signature: _____ Date: _____

2003 Lower State Road, Building 200, Doylestown, PA 18901. P (215) 345-6647. F (215) 345-0460
920 Lawn Avenue, Suite 6, Sellersville, PA 18960. P (267) 354-1440. F (267) 354-1292

DERMATOLOGY & MOHS SURGERY CENTER, PC

RELEASE OF INFORMATION AND FINANCIAL POLICY

Financial Policy:

Thank you for choosing Dermatology and Mohs Surgery Center, PC as your health care provider.

If you have health insurance coverage:	If you do not have health insurance or if you request a cosmetic procedure:
• You are responsible for supplying us with current, correct insurance information.	• Payment in full is due at the time of service.
• Please notify us of any changes in your address or telephone number.	• We accept cash, Visa, MasterCard, Discover and American Express
• You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company.	• Patients scheduled for surgery must submit check payments 14 business days prior to surgery. Cash, Visa, MasterCard, Discover or American Express payments must be submitted 7 business days prior to surgery.
• Referrals (for HMO patients) are your responsibility and must be current prior to your visit	
• All co-pays and your estimated portion, including any deductibles and/or co-insurances, will be expected at the time of service.	
• You may not self-pay, and then ask us to file your insurance at a later time.	

Our business office is available from 10:00a - 4:00p, Monday through Friday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you. If you disagree with the balance for any reason please contact our business office immediately at (215) 345-6647.

A $25.00 fee will charged or all returned checks.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by Dermatology and Mohs Surgery Center, PC. I understand and agree that if the office places my account with an agency or attorney for collection, the offices shall be paid by me for all collection costs to the extent allowed by applicable law.

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

Patient Signature:_____ **Date:** _____

Release of Information:

Please indicate with whom we can leave a message regarding appointments and test results:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient Signature:_____ **Date:** _____

Receipt of HIPAA Policy:

I acknowledge I have received or declined a copy of Dermatology and Mohs Surgery Center, PC's Notice of Privacy Policy. This is available from our receptionist or on our website at www.dermatologyandmohs.com.

Patient Signature:_____ **Date:** _____