University Dermatology and Skin Cancer Center

Patient Information

Referring Physician: _____ **Primary Care Physician** _____

Patient Name _____ _____ _____ M ( ) F ( )
First Middle Last

Mailing Address _____ _____ _____ _____
Street or PO Box City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ___/___/___ Social Security # _____ Email-_____

Race: White___ Black___ Hispanic___ Asian___ Am. Indian___ Other_____

Preferred Language: English____ Spanish____ Other_____

(Circle One) Single Married Divorced Widowed Employer _____

Responsible Party (Person Responsible for Payment if different from Patient or is a minor)

Name _____ _____ _____ Relationship to Patient _____
First Middle Last

Mailing Address _____ _____ _____ _____
Street or PO Box City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ___/___/___ Social Security # _____ Employer _____

Insurance Information
(Copy of insurance card is required. If card not available, you will be entered as self pay until card is available)

PLEASE CHECK ONE: INSURANCE _____ **SELF PAY** _____

Primary Insurance Name _____

Primary Policy Holder Name (if different from patient)_____ Date of Birth ___/___/___

Secondary Insurance _____ Other _____

Secondary Policy Holder Name (if different from patient)_____ Date of Birth ___/___/___

Patient Portal and Appointment Reminders

__ I would like an invite to the portal e-mailed to the provided e-mail address above.

__ I would not like an invite to the portal at time because I do not have a computer, or I choose to opt out.

How did you hear about out practice: Physician Referral , Mailing, Social Media, Radio, Other:_____

HIPAA REQUIREMENTS

***UDSCC* cares about patient privacy. Health Insurance Portability and Accountability Act (HIPAA) updated their guidelines in September 2013.**

___I would like to read these guidelines ___I would not like to read these guidelines. ___I would like a copy of these guidelines. _____ (please initial).

Please provide names of persons that we may release your medical information to:

Name	Phone	Relationship	Add as Emergency Contact?
_____	_____	_____	Y / N
_____	_____	_____	Y / N

May non-medical information be left on your answering machine? Yes ____ No ____ Don't have one ___
May we call you at work? Yes ____ No ____ Don't work ____

I would like to get appointment reminders for upcoming appointments. Our office utilizes phone, text messaging and email for reminder messages. Yes ____ No____ Text message opt out____ Email opt out ____

_____ **Date:**_____
Patient or Parent Signature

AUTHORIZATION TO TREAT, OBTAIN AND RELEASE MEDICAL INFORMATION

I, the undersigned, authorize UDSCC and his staff to perform any procedures and take any photographs as necessary to diagnose and treat my conditions.
I hereby authorize UDSCC to obtain medical records and pharmacy records from other sources as may be needed for treatment.
I hereby authorize UDSCC to release information concerning this patient's treatment to other physicians involved in their care and treatment.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

I, the undersigned, authorize the release of any medical or insurance information to the Social Security Administration and Health Care Financing Administration or the stated insurance company necessary to process insurance claims for services rendered by this facility. I hereby authorize (Ins. Co). _____ to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.

PAYMENT POLICY:

****Please make sure we have complete, correct insurance and address information when you check in for <u>each visit</u>. It is <u>your</u> responsibility to make sure we have the information to file your claims correctly the first time. ****

MEDICARE: We are participating providers of the Medicare Program. We will accept assignment on all claims. Patients are responsible for meeting their deductible and paying the 20% coinsurance. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

HMO, PPO, OR OTHER MANAGED CARE PATIENTS: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services. Please note: most office procedures go against your deductible, if applicable.

SELF PAY: You will be expected to pay in full for your office exam and any procedures preformed unless arrangements have been made with the office manager.

PATIENT BALANCES: You will be expected to make payment within a timely manner. If the account becomes delinquent with no consecutive payments being made it will be placed with a third party collection agency and an additional 28% fee will be accrued.

NO SHOW POLICY: You will be expected to pay a $25 fee for all appointments cancelled/rescheduled without a 24 hour notice, as well as all no show.

Patient or Parent Signature:_____**Date:**_____

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Medical History Form

Patient: _____ **DOB:** _____ **Date:** _____

Preferred Pharmacy: _____ **Who is your primary care provider (PCP)?** _____

Can we electronically import your current medications from your pharmacy? Yes ○ No ○

Allergies to Medications: ○ NKDA ○Yes/List: _____

Adverse Reaction to Local Anesthesia &/or Latex: ○ No ○Yes/List: _____

Social History: *Smoking* ○No ○Former ○ Yes/packs per day _____ *Alcohol* ○No ○Yes/How much _____

Drug Addictions/Abuse: ○No ○Yes/List _____ **Marital Status:** ○Single ○Married ○Divorced ○Widowed

Occupation: _____ **Hobbies**? _____

(Women) Are you pregnant? ○No ○Yes **Are you actively trying to become pregnant?** ○No ○Yes **Are you breastfeeding?** ○No ○Yes

Personal & Family Skin History: Circle all that applies regarding your health

Have you ever had a skin cancer?

None Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma

Yes/unsure of type Other _____

Location of Skin Cancers & Treatment Type:

_____

Did any require additional treatment such as radiation therapy, chemotherapy, &/or lymph node removal? Y or N

Has anyone in your family had a skin cancer?

None Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma

Yes/unsure of type Who? _____

Have you ever had any of the following:

Dysplastic Nevi/Abnormal Moles Blistering Sunburn Psoriasis Keloid/Hypertrophic Scars

Details: _____

Have you ever used a tanning bed? Never Former User Present User / How long & often? _____

Do you wear sunscreen? No or Yes/SPF _____

Other pertinent skin information: _____

Do you currently have or have you ever had?

Leukemia/Lymphomas/Cancers (non-skin related): _____

Organ Transplant or Stem Cell Transplant: _____

Immunocompromised? _____

Major Illnesses/Hospitalizations: _____

Radiation Treatment: _____

Patient Name: _____

Past Medical History: Please circle any that apply to your past and/or current medical history

Anxiety/Depression	Diabetes	Multiple Sclerosis
Arthritis	Hepatitis B / Hepatitis C	Osteoporosis
Rheumatoid Arthritis	High Blood Pressure	Prostate Enlargement
Asthma	High Cholesterol	Hay Fever/Allergies
Atrial Fib/Irregular Heartbeat	HIV/AIDS	Seizure
Crohn's / Ulcerative Colitis	Kidney Disease/Dialysis	Stroke
COPD	Liver Disease/Cirrhosis	Thyroid Disease-Low or High
Coronary Artery Disease	Lupus	Tuberculosis

Other: _____

Surgical History: Please circle any that apply to your past and/or current surgical history

1. **Pacemaker and/or Defibrillator** **Which:** Pacemaker Defibrillator Both
2. **Artificial Heart Valve** **Type:** Mechanical or Bioprosthetic
3. **Heart Bypass Surgery and/or Stents**
4. **Joint Replacement** **Joint:** Hip Knee Shoulder **Side:** Right Left Both **When?** _____
5. **Breast Cancer** **Surgery:** Lumpectomy or Mastectomy **Side:** Right Breast Left Breast Both
6. **Major Surgeries** _____

Do you currently have any of the following?

Cough / Shortness of Breath / Wheezing / Chest Pain / Blurry Vision / Hay Fever / Rash

Fever / Chills / Night Sweats / Unintentional Weight Loss / Sore Throat / Swollen Nodes / Thyroid Disease

Anxiety / Depression / Headaches / Seizures

Neck Stiffness / Joint Aches / Muscle Weakness / Abdominal Pain / Bloody Stool / Bloody Urine

History of problems with: Bleeding / Healing / Scarring

Please list ALL current medications, including over-the-counter and supplements:

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____