Patient Information

Today's Date: _____

Name: _____
Last *First* *M.I*

Date of Birth: _____ Age: _____ Sex: Male O Female O

Social Security Number: _____ Married O Single O

Mailing Address: _____

_____
City *State* *Zip*

Home Phone : _____ Cell Phone: _____

E-mail: _____

Name and address of PERSON RESPONSIBLE for for bill, If not patient:

O Spouse O Dependant O Other O

_____
Name

_____
Address City State Zip

Primary Insurance Carrier:

Relationship to Policy Holder: Self O Spouse O Dependant O

Name of Policy Holder (if not self): _____

Date of Birth of Policy Holder (if not self): _____

Social Security Number (if not self): _____

Address of Policy Holder (if not self): _____

_____
City *State* *Zip*

Secondary Insurance Carrier: _____

Relationship to Policy Holder: Self O Spouse O Dependant O

Name of Policy Holder (if not self): _____

Date of Birth of Policy Holder (if not self): _____

Social Security Number (if not self): _____

Address of Policy Holder (if not self): _____

_____
City *State* *Zip*

If a Physician Referred you to our office, Please give the name of the Physician

_____

Whom may we contact in the event of an emergency? _____

Contact phone number: _____

Please list pharmacy of choice: _____

How did you hear about our practice?

Billboard TV Phone Book Internet Friend Other: _____

Please present your insurance card(s) and a photo ID
to the receptionist along with this completed form.
Thank You

HISTORY & INTAKE FORM – pg. 1

PATIENT NAME	DATE OF BIRTH	TODAY'S DATE

Past Medical History: (please circle all that apply)

Anxiety	Diabetes	Lung Cancer
Arthritis	End Stage Renal Disease	Lymphoma
Asthma	GERD	Prostate Cancer
Atrial fibrillation	Hearing Loss	Radiation Treatment
Bone Marrow Transplant	Hepatitis or Fatty Liver	Seizures
Breast Cancer	High Blood pressure	Stroke
Colon Cancer	HIV/AIDS	
COPD	High Cholesterol	**NONE**
Coronary Artery Disease	Thyroid Problems	
Depression	Leukemia	

Females of childbearing potential
Do you use contraception Yes No If yes, which method?_____

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement, Hip (Right, Left, Bilateral)
Bladder Removed	Joint Replacement within last 2 years
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Reduction	Kidney Transplant
Breast Implants	Ovaries Removed: Endometriosis
Colectomy: Colon Cancer Resection	Ovaries Removed: Cyst
Colectomy: Diverticulitis	Ovaries Removed: Ovarian Cancer
Colectomy: IBD	Prostate Removed: Prostate Cancer
Gallbladder Removed	Tubal Ligation
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	**NONE**

Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	**NONE**

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? Yes No
If yes, which relative(s)? _____

HISTORY & INTAKE FORM – pg. 2

_____ _____ _____

PATIENT NAME **DATE OF BIRTH** **TODAY'S DATE**

Social History: (Please circle all that apply)

History of IV/Drug Use: YES NO

Cigarette Smoking:
Currently Smokes/Dips Tobacco
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Family History (only first degree relatives-CANCER, DIABETES, HEART DISEASE, HYPERTENSION) _____

_____

Medications: (Please enter all current medications)

Name of Medication	Strength	How often do you take this medication?

Drug Allergies: (Please enter all allergies)

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant? Due Date: _____
Trying to get pregnant.

Grafton Dermatology & Cosmetic Surgery

Billing Policies

I understand that I am responsible for payment of this account, subject to the terms noted below. I also agree to present my insurance card each visit to Grafton Dermatology & Cosmetic Surgery (GDCS) in order to allow for verification of insurance carrier information on file.

PRIVATE INSURANCE – As a courtesy to me, GDCS will file my claims based on the information provided. Should this information prove incorrect, I am responsible to pay the balance in full. I agree that my insurance benefits may be paid directly to GDCS and payment of all deductible(s) and co-payment(s) are required at the time of service. Any allowable amount not paid by my insurance carrier must be paid within 30 days of receipt of a statement.

MEDICARE – GDCS accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s) or co-payment(s). If there is a Medicare supplement insurance policy, GDCS will file my claim as a courtesy to me, and the benefits may be sent directly to GDCS.

MEDICAID – I understand that GDCS accepts Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or denies these benefits, I agree to be responsible for payment of the account.

WORKER'S COMPENSATION – I agree to allow GDCS to verify my Worker's Compensation coverage with my employer or my employer's insurance carrier. The employer or insurance carrier may request medical information in order to process claims. Any requested information sent to my employer or the insurance carrier will also be provided to me. I agree to be responsible for payment of all charges which are not paid by my employer or its Worker's Compensation insurance carrier.

NO INSURANCE- If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges at the time of service.

RELEASE OF INFORMATION – Should my insurance carrier, Medicaid, or Medicare request medical information and/or copies of my medical records in order to process my claim(s), GDCS has my permission to furnish.

If I fail to make any payment due as outlined above or as agreed upon, GDCS may turn this account over to a collection agency for handling.

_____ _____

Signature **Date**

Missed and Late Arrival Appointment Policy

When patients fail to show up for their appointments, other patients who need appointments are unable to receive the care they require if we don't have enough notice to be able to fill the empty appointment times. Our policy on late arrivals, cancelations and no-shows is based on experience and is a critical part of operating our clinic.

Please confirm your appointment: Grafton Dermatology & Cosmetic Surgery will contact you prior to your appointment by text. You must reply to the text to confirm your appointment. It is easy as responding "YES" to the text. This will confirm your appointment. If you are unable to make your appointment you can text us back stating you want to cancel. You can also reschedule or move your appointment to another time by texting. Our staff will respond within minutes unless outside of business hours, in which case they will respond as soon as the office opens the next day.

If you do not confirm your appointment, Grafton Dermatology & Cosmetic Surgery reserves the right to reschedule you.

Late arrivals: Please keep in mind that Grafton Dermatology & Cosmetic Surgery maintains a full schedule. Even one patient running late can impact the schedule of the entire clinic. Please call us and let us know if you are running behind so we can manage accordingly.

Cancelations: If you need to cancel or reschedule your appointment, please give our office at least 24-hour notice so we have time to fill the appointment slot with another patient.

Failure to give a 24- hour notice is considered a missed appointment

Consequences of missed appointments: The first missed appointment within six months will be noted in the chart. The second missed appointment within six months will result in a 30 day delay before you can reschedule. The third missed appointment within six months will result in you no longer being able to be seen.

All Cosmetic & Surgery missed appointments will be charged $50.00

I understand Grafton Dermatology & Cosmetic Surgery's appointment policy.

I agree to confirm my appointment at least 24 hours ahead of time.

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

Confidential Communication Request

(HIPPA) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a ***federal law*** *that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.*

From time to time in caring for our patients, it may become necessary to contact you by phone. Often our patients are not available when we call them and we would like to be able to leave a message (i.e. lab results) when possible.

In order to protect your privacy we need your written permission to leave a message on your answering machine, voice mail system or with a trusted family member, text message to a cellular phone, and e-mails.

Please read the following choices to give us permission:

Yes No Contact you via e-mail?

_____ *E-mail address*

Yes No Cell phone voice mail?

_____ *Cell Phone Number*

Yes No May we discuss appointments, labs or treatment with your spouse?

_____ *Spouse Name*

Yes No Is there any other person, other than your spouse, that you would want us to discuss appointments, labs or treatment with?

_____

Name *Relationship*

_____

Name *Relationship*

Yes No May we send lab results to your PCP?

_____ *PCP Name*

You must inform us, in writing, of any changes in your directives. This record takes effect on the date below and will be kept in your file.

_____ _____

Signature *Date*