

PLEASE FILL OUT ENTIRELY

AAP DERMATOLOGY & COSMETIC SURGERY, P.C. - RONALD M. GLICK, D.O.

Did another doctor refer you to our office? (Name of Dr.) _____

Legal Name of Patient: _____

(Sex) Circle One
Male - Female

(Last) (First) (MI) (Birthdate) (Age)

Prefer to be called _____

Social Security # _____ (For identification purpose only & if your insurance requires)

Marital Status (Circle) Married - Single - Widowed - Divorced - Spouse's Name _____

Language _____ Ethnicity _____ Race _____

AZ Address: _____ Apt # _____ City/State _____ Zip _____

Phone (Area Code & #) Home _____ Work _____ Cell _____

2nd Home Address, if applies: _____ City/State/Zip _____ Phone _____

**What months are you there? _____

Primary Care Physician Name _____ Address _____ Phone _____

Pharmacy/Location(cross streets) _____ Pharmacy Phone# _____

Email: _____ Pharmacy Fax# _____

CASE OF EMERGENCY, Person to Contact: _____ Phone: _____

Can we leave medical information or test results on your answering machine? Yes No

Can we discuss medical information or test results with family members? Yes No

If yes, identify their names and relationship to you.

Name _____ Relationship _____

Name _____ Relationship _____

**ADULTS: PLEASE FURNISH US WITH YOUR DRIVER'S LICENSE SO WE MAY COPY IT. THIS
ALLOWS OUR PRACTICE THE ABILITY TO VERIFY PATIENT IDENTITY.**

INSURANCE INFORMATION

What is the name of your primary insurance carrier? _____ Co-pay _____

What is the name of the insured on the primary insurance? _____

Insured's Social Security # _____ Birthdate _____ Relationship to insured? _____

If insurance is through an employer, please list name of employer _____

What is the name of your secondary insurance carrier? _____

What is the name of the insured on the secondary insurance? _____

Insured's Social Security # _____ Birthdate _____ Relationship to insured? _____

**PLEASE GIVE US YOUR INSURANCE CARD(S) SO THAT WE MAY COPY THEM
FOR OUR RECORDS. This will insure correct billing.**

Assignment & Release: I hereby assign my insurance and or Medicare benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim in the course of my exam and treatment. I authorize and request my insurance company to pay directly to AAP Dermatology and Cosmetic Surgery, PC the amount due me in my pending claim for medical, major medical or surgical treatment or services by reason of such treatment or services rendered. I understand that if my AAP Dermatology and Cosmetic Surgery, PC financial account needs collection, all collection fees will be added to the original balance.

E-Prescribing: I content for AAP Dermatology and Cosmetic Surgery, PC provider(s) to electronically access information regarding my drug benefit coverage and medication history.

Signature: _____ **Date:** _____

Parent Signature if patient is a minor: _____ **Date:** _____

PATIENT HISTORY

Name: _____ Date: ____/____/____

Marital Status: (Circle) Single / Married / Divorced / Widowed | Male ___ Female ___ Age ___ Height ___ Weight ___

Occupation: _____ Hobbies: _____

Reason for Visit? _____

List - past major surgeries: _____

DIAGNOSIS:	PERSONAL HISTORY		FAMILY HISTORY	
	Yes	No	Yes	No
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes/Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Human Immunodeficiency Virus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint/Muscle Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Valley Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY
Please Specify:
Parents, Grandparents, Siblings

ALLERGIES	Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Any Antibiotic Medications	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Adhesive tape	<input type="checkbox"/>	<input type="checkbox"/>
Any foods	<input type="checkbox"/>	<input type="checkbox"/>
Other Allergy?	<input type="checkbox"/>	<input type="checkbox"/>

If (YES) to any of the above, please explain your reaction:

List Current Medications:

	Yes	No	(Describe)
Cortisone/Prednisone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herbal medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee - amount per day	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol - amount per day	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco - amount per day	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females Only: Are You?
 Pregnant yes no
 Breast Feeding yes no
 Trying to get Pregnant yes no
 Birth Control Pills yes no
 Most recent PAP smear? ____/____/____

Sexually Active:
 is sexually active and using birth control
 is sexually active and is not on birth control
 is not sexually active

If (YES) to any of the above, please explain:

Name of Previous Skin Doctor

Prior Skin diagnoses and treatments?

Other Medical Problems?

Patient Signature: _____

BILLING POLICIES

PATIENT PAY/NO INSURANCE: To better serve the patient and keep operating costs to a minimum, payment is due at the time of service. For your convenience, payment will be accepted in the form of cash, check, or credit card.

“I am a self-pay patient and will not be using any form of insurance. I understand that payment of my bill is expected today.”

Name _____ Date _____

FILING CLAIMS WITH YOUR INSURANCE: AS A SPECIAL SERVICE TO YOU, we will bill your insurance plan for covered services. If your insurance company does not pay us within 30 days of billing, we will bill you for the services. If the insurance company then pays us after you have paid us, we will reimburse you.

“I understand that AAP Dermatology & Cosmetic Surgery will bill my insurance company for covered services. If my insurance company does not pay AAP Dermatology within 30 days, I understand that I will be billed for these services.”

Name _____ Date _____

IF YOU ARE COVERED BY MEDICARE, AHCCCS, BLUE CROSS/BLUE SHIELD OR ANY HMO OR PPO THAT WE ARE CONTRACTED WITH, PLEASE READ THE FOLLOWING:

MEDICARE: Because we “accept assignment” with the Medicare program, it is mandatory that we file your claim directly with the Medicare carrier. When Medicare determines the “allowable charges,” we will then bill you for any deductible or 20% co-insurance as determined by Medicare. Federal Law requires that we bill you for all monies applied to your deductible and all 20% co-insurance. Please be sure that the staff has a copy of your Medicare card.

IF YOU HAVE A SECONDARY CARRIER AFTER MEDICARE: If you wish your secondary insurance company be billed, please give us all of the pertinent information we will need to bill them.

HMO/PPO ENROLLEES: Each HMO and PPO has their own specific contract. Your plan co-payment is due on the date of service. We will then bill the service to your PPO or HMO. In addition to the co-payment, some plans require deductibles to be paid. If your carrier notifies us that you have additional responsibilities to us with regard to additional payment beyond your co-pay, we will bill you after hearing from them.

TO BILL YOUR INSURANCE AND ALLOW THE INSURANCE COMPANY TO EXAMINE YOUR RECORDS, PLEASE SIGN BELOW:

“I authorize the release of any medical record or other information necessary to process my insurance claim. I also request that payment for medical benefits be made to AAP Dermatology & Cosmetic Surgery, P.C.”

Signature of Patient or responsible party _____

Date _____