SOUTH COAST DERMATOLOGY

PATIENT INFORMATION

Patient Name:	
Address One:	**Date of Birth:**
Address Two:	**Sex:**
City:	**Emergency Contact:**
State: **Zip:**	**Emergency Phone#:**
Home Phone#:	**2nd Emergency Phone#:**
Work Phone#:	**Usual Provider:**
Cell Phone#:	**Primary Care:**
Email Address:	**Referring Doctor:**

GUARANTOR INFORMATION

Guarantor Name:	**Home Phone#:**
Address One:	**Work Phone#:**
Address Two:	**Cell Phone#:**
City:	**State:** **Zip:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Policy#:	**Policy#:**
Group #:	**Group#:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**

Can we release test results to family members?

No / Yes (Name):

Do you have a HealthCare proxy?

Yes / No Name:

Insurance Authorization and Assignment:

I hereby authorize SOUTH COAST DERMATOLOGY, to furnish information to insurance carriers concerning my illness & treatment & I hereby assign to the physician(s), all payments for medical services rendered to myself or my dependents.

I understand I am responsible for any amount not covered by insurance at the time of service.

SIGNATURE: _____ **DATE:** _____

The policy is regarding keeping a credit card number on file for each patient in the instance that there is an outstanding balance.

CREDIT CARD POLICY

It is the policy of this office to obtain from you today a valid credit card number in the event of an unpaid balance on your account. You can be assured that your credit card information will be held securely, and only utilized for non-covered services, unmet deductibles, services rendered and co-payments. Before your credit card is charged, your insurance company, if applicable, is billed for all covered services. After that billing cycle, you are then sent a bill for any outstanding balances on your account which allows you the opportunity to question or dispute the charge and to pay conventionally through the mail. **Your credit card will only be charged if there is no response to your bill. A receipt is then mailed directly to you with another copy of your bill.**

The credit card number is encrypted by the Retrievex System and no one can access the card number. The card is used only for an outstanding balance due to a deductible, copayment, non-covered service, failure from insurance company to pay for services or failure to obtain a referral if required from primary care provider.

CANCELLATION POLICY

A fee of $40 will be charged for any missed appointment if 24 hours notice is not given, unless acceptable documentations of an emergency is provided

_____ACCEPT CREDIT CARD ON FILE _____DECLINE CREDIT CARD ON FILE

SOUTH COAST DERMATOLOGY PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have been offered and have the right to review the Notice of Privacy Practices prior to signing this consent.

I hereby give my consent for South Coast Dermatology to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). South Coast Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

South Coast Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to South Coast Dermatology Privacy Officer at:

90 Libbey Industrial Parkway- Suite 200
Weymouth, MA 02189

With this consent, South Coast Dermatology may call my home or alternate number, leave a message on voice mail or in person, or mail to my home, in reference to any items that assist the practice in carrying out my TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care including laboratory results among others.

By signing this form, I am consenting to South Coast Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian **Date**

Preferred Language: **(please circle)**

English
Spanish
Mandarin
Cantonese
Arabic
Azerbaijani
Bengali
Burmese
Croatian
Dutch
French
German
Gujarati
Hindi
Hebrew
Italian
Japanese
Javanese
Korean
Malayalam
Panjabi
Persian
Polish
Portuguese
Romanian
Russian
Serbian
Tamil
Thai
Turkish
Ukrainian
Urdu
Vietnamese
Farsi
Wu
Telgulu
Marathi
Kannada
Samoan

Race: **(please circle)**

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

Ethnic Group: **(please circle)**

Hispanic or Latino

Not Hispanic or Latino

Unknown

Employment Information

Employer's Name

Occupation

Place of Birth

City

State

Country

Zip

Name: **DOB:**

What is your occupation?_____

Present Problem

What is the reason for your visit? _____

_____

_____

_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial Fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV / AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	
Coronary Artery Disease	Hypothyroidism	None

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 Biopsy
Lumpectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Breast Biopsy (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	Prostate Biopsy
Coronary Artery Bypass	TURP
PTCA	Skin Biopsy
Mechanical Valve Replacement	Basal Cell Cancer Surgery
Biological Valve Replacement	Squamous Cell Carcinoma Surgery
Heart Transplant	Melanoma Surgery
Joint Replacement, Knee (Right, Left, Bilateral)	Spleen Removed

Past Surgical History Continued:

Testicles Removed (Right, Left, Bilateral)

Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other: _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itching 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

Family History:

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? Brother Sister Father Mother Son Daughter
Do you have a family history of:
Basal cell carcinoma ? Yes No
Squamous cell carcinoma? Yes No
If yes, which relative(s)? Brother Sister Father Mother Son Daughter

PHARMACY NAME: _____
ADDRESS: _____
TEL: _____

Have you taken aspirin or Vitamin E in the past week? _____ yes _____no

Medications: (Please enter all current medications and **dosage**)

_____
_____
_____

Allergies: (Please enter all allergies including to medications)

_____
_____
_____

Social History: (Please circle all that apply)

Currently Smokes- daily	Has never smoked
Currently Smokes- not daily	Drug Use
Has smoked in the past	None

Other: _____

How often do you drink alcohol? (Please circle) None, less than1 drink per day, 1-2 drinks per day, 3 or more drinks per day

Review of Systems: Please check all that apply.

Symptom	Yes	No
Have you had a Pneumonia Vaccination this year?		
Have you had a FLU Vaccination this year?		
Pacemaker		
Defibrillator		
Artificial Joints within Past Two Years		
Artificial Heart Valve		
Premedication Prior to Procedures		
Allergy to Adhesive		
Allergy to Topical Antibiotic Ointments		
Blood Thinners		
Pregnancy or Planning a Pregnancy		
Allergy to Lidocaine		
Rapid Heart Beat with Epinephrine		
Yeast Infections with Antibiotics		
GI Upset with Antibiotic		
Problems with Bleeding		
Problems with Healing		
Problems with Scarring (Hypertrophic or Keloid)		
Immunosuppression		
Changing Mole		
Rash		
Abdominal Pain		
Anxiety		
Bloody Stool		
Bloody Urine		
Blurry Vision		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Seizures		
Shortness of Breath		
Sore Throat		
Unintentional Weight Loss		
Wheezing		
Hepatitis A, B, C (Circle any that apply)		
HIV / AIDS		
Heart Failure		
Coronary Artery Disease(CAD)		
Chronic Obstructive Pulmonary Disease (COPD)		
Diabetes Type I or Type II		
HIV/AIDS		