Medical Intake Form

PRECISION SKIN INSTITUTE

PATIENT INFORMATION			
LAST NAME	FIRST NAME	M.I.	DATE / /
STREET ADDRESS	APT #		HOME PHONE ( )
CITY	STATE	ZIP	MOBILE PHONE ( )
DRIVERS LICENSE NUMBER (Optional)		LAST 4 DIGITS OF S.S. #	
D.O.B. / / AGE	GENDER O MALE O FEMALE	EMAIL	
MARITAL STATUS O MARRIED O SINGLE O DIVORCED O WIDOWED	PREFERRED LANGUAGE (IF OTHER THAN ENGLISH)		
MINOR/UNDER 18 YEARS OLD O YES O NO	GUARDIAN NAME		GUARDIAN PHONE ( )
EMPLOYER		OCCUPATION	
EMPLOYERADDRESS	CITY STATE	ZIP	EMPLOYER PHONE ( )
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT		PHONE ( )
PRIMARY CARE PHYSICIAN			PHONE ( )
HOW DID YOU HEAR ABOUT US?			
O OUR WEBSITE (PRECISIONSKININSTITUTE.COM)	O INSURANCE WEBSITE OR LIST	O MAGAZINE	O FACEBOOK
O ANOTHER PATIENT	O REFERED BY DOCTOR	O OTHER	
ALTERNATE ADDRESS _____			

PERSON RESPONSOBLE FOR PAYMENT IF PATIENT UNDER 18 YEARS OF AGE			
LAST NAME OF PERSON RESPONSOBLE FOR BILL	FIRST NAME	M.I.	HOME PHONE ( )
STREET ADDRESS		APT #	MOBILE PHONE ( )
CITY	STATE ZIP	RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION			
PRIMARY INSURANCE	POLICY #	GROUP #	
PRIMARY INSURANCE POLICY HOLDER	RELATIONSIP TO PATIENT		D.O.B. / /
SECONDARY INSURANCE	POLICY #	GROUP #	
SECONDARY INSURANCE POLICY HOLDER	RELATIONSHIP TO PATIENT		D.O.B. / /

CONSENTS

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payments of medical benefits to Precision Skin Institute _____.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Payment is required for all services at the time they are rendered (this includes co-payments, deductibles, co-insurance, deposits and payments for cosmetic services). I have had a chance to read over the Financial Repsonsibility Form. If your account remains unpaid past 60 days a $20.00 late fee will be added to all subsequent billing statements. Any accounts 90 days or more overdue will be referred to a collection agency and incur a 35% interest charge.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

I have had a chance to read over the HIPAA/Privacy Policy Form.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Please initial if we are non-par with insurance plan of if patient has no insurance coverage _____

Medical History Form

PRECISION SKIN INSTITUTE

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	DATE
			/ /

PAST MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY

- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ARTRIAL FIBRILLATION
- ☐ BREAST CANCER
- ☐ COLON CANCER
- ☐ COPD
- ☐ CORONARY ARTERY DISEASE
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ RENAL DISEASE
- ☐ GERD (reflux)
- ☐ HEARING LOSS
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ HIGH CHOLESTEROL
- ☐ LEUKEMIA
- ☐ LUNG CANCER
- ☐ LYMPHOMA
- ☐ PROSTATE CANCER
- ☐ RADIATION TREATMENT
- ☐ SEIZURES
- ☐ STROKE
- ☐ HYPOYTHYROID/HYPERTHYROID
- ☐ OTHER _____

PAST SURGINCAL HISTORY INCLUDING SKIN SURGERY (description/date)

_____ _____ _____

SKIN DISEASE HISTORY

PLEASE CHECK ALL THAT APPLY

- ☐ ACNE
- ☐ ACTINIC KERATOSES
- ☐ ASTHMA
- ☐ BASAL CELL CARCINOMA
- ☐ BLISTERING SUNBURNS
- ☐ DRY SKIN
- ☐ ECZEMA
- ☐ FLAKING / ITCHY SCALP
- ☐ HAY FEVER / ALLERGIES
- ☐ MELANOMA
- ☐ POISON IVY
- ☐ PRECANCEROUS MOLES
- ☐ PSORIASIS
- ☐ SQUAMOUS CELL CARCINOMA
- ☐ OTHER _____

SUN DAMAGE AND SUNSCREEN INFORMATION

DO YOU WEAR SUNSCREEN?	TAN IN A TANNING SALON?	DO YOU SPEND LONG HOURS IN THE SUN?	
☐ YES, (SPF _____) ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	

MEDICATIONS

MEDICATIONS

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES TO MEDICATIONS

_____ _____ _____

SOCIAL HISTORY

PLEASE CHECK ALL THAT APPLY AND PROVIDE APPLICABLE INFORMATION

☐ CIGARETTE SMOKING
- ☐ CURRENTLY DAILY SMOKER
- ☐ SOME DAY SMOKER
- ☐ NEVER SMOKED
- ☐ FORMER SMOKER

OPTIONAL
- ☐ NOT SEXUALLY ACTIVE
- ☐ SEXUALLY ACTIVE
  - ☐ 1 PARTNER
  - ☐ MORE THAN 1 PARTNER
  - ☐ SAME SEX PARTNER

- ☐ DRUG USE
- ☐ IV DRUG USE

☐ ALCOHOL USE
- ☐ NONE
- ☐ LESS THAN 1 DRINK
- ☐ 1-2 DRINKS DAILY
- ☐ 3 OR MORE DRINKS DAILY

FAMILY HISTORY OF SKIN DISORDERS AND/OR SKIN CANCER (1st degree relatives only)

PHARMACY INFORMATION

PHARMACY NAME	LOCATION	PHONE
		( )

ALERTS

PLEASE CHECK ALL THAT APPLY AND PROVIDE APPLICABLE INFORMATION

ALLERGY TO
- ☐ ADHESIVE (BANDAID)
- ☐ LIDOCAINE (NUMBING AGENT)
- ☐ TOPICAL ANTIBIOTICS

CURRENT CONDITIONS
- ☐ ARTIFICIAL HEART VALVE/JOINT
- ☐ DEFIBRILLATOR
- ☐ PACEMAKER
- ☐ HISTORY OF MRSA
- ☐ PREGNANT
- ☐ NURSING
- ☐ REQUIRE ANTIBIOTICS PRIOR TO SURGERY
- ☐ RAPID HEARTBEAT WITH EPINEPHRINE

COSMETIC HISTORY

HAVE YOU EVER HAD A COSMETIC PROCEDURE?

☐ YES, (ANY SIDE-EFFECTS? _____)

☐ NO

ARE YOU INTERESTED IN A COSMETIC PROCEDURE?

☐ YES, (PLEASE SPECIFY _____)

☐ NO

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have been either given a copy of Notice of Privacy Practices if I requested one. I understand that the practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy. The Notice of Privacy Practices as well as Patients' Bill of Rights are also posted in the waiting area and can also be found on our website at **www.precisionskininstitute.com.**

FINANCIAL POLICY

Due to the many changes in insurance policies it is no longer an easy task to interpret each individual policy, therefore we urge you, the patient to please make sure you understand your individual policy and how it applies to your payment responsibility. **Please remember that your insurance policy is between you and your insurance company.** If you require a referral to see a specialist it is your responsibility as the patient to obtain this referral before your office visit. Failure to do so will result in your appointment being re-scheduled. **If you have a co-payment or out-of-pocket expenses, deductible, co-insurance etc. it must be paid at the time of service.**

CANCELLATION AND NO-SHOW POLICY

Our office and providers want to ensure that all of our patients receive the best possible care. In order to do so, we try to ensure that all of our patients are seen in a timely fashion. When a patient does not cancel or show up for his/her appointment, the ability of others to be seen in a timely fashion is affected as this appointment goes un-used. Our policy is as follows:
24 hour notice must be given for General Dermatology appointments and 48 hour notice must be given for any cosmetic/surgical or appointments with our estheticians.

Please be aware that you are NOT able to cancel or re-schedule your appointment via our reminder system you must contact the office to do so.

Failure to provide the proper notice or failure to show up for your scheduled appointment will result in the loss of your deposit or being charged a fee as below:

$25.00	Regular Office Visit
$50.00	Surgical appointment
$100.00	Cosmetic Procedure/Laser appointment and Esthetician appointment
$150.00	Appointment scheduled for 40 minutes or longer

DEPOSIT POLICY

A deposit is required for any cosmetic procedure and/or Esthetician Appointment.

_____ _____ _____

Patient Name (print clearly) **Patient Signature** **Date**