Anderson Dermatology & Skin Surgery Center, LLC

PATIENT INFORMATION __New Patient __Name Change __Address Change __Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS **Todays Date: __/__/___**

Name ____/________________

Last *First* *M.I.* *Preferred Name*

Date of Birth __/__/__ Age: __ SS #: _______________Birth Sex __M__F

Height __________ Weight ________

ADDRESS

Mailing Address____

City *State* *Zip*

Home Phone ( )______________________ Cell Phone ( )______________________

E-Mail ________________________________

Marital Status ___Single ___Married ___Divorced ___Widowed ___Separated

Emergency Contact ___________________________ Phone#_____________________

GUARANTOR INFORMATION:

Who is financially responsible for this account? SELF FATHER MOTHER OTHER

Name____ Date of Birth ___/___/____

Address ____

City *State* *Zip*

Home Phone ( )______________________ Work Phone: ( )______________________

INSURANCE COVERAGE – PRIMARY:

Insurance Co. Name____

Name of Policy Holder (Insured) ____

Policy Holder (insured) Date of Birth ____/____/____ SS#___________________________

If patient is child, check relationship __Mother __Father __Spouse Other________________

INSURANCE COVERAGE—SECONDARY:

Insurance Co. Name ____

Name of Policy Holder (Insured) ____

Policy Holder (insured) Date of Birth ____/____/____ SS#___________________________

If patient is child, check relationship __Mother __Father __Spouse Other________________

Do you give our office permission to discuss your medical information with anyone other than you?

____YES ____NO If yes, please provide their names and phone numbers below.

Name______________________Phone________________Relationship__________________

I authorize you to communicate with me by text, voicemail, email, and home answering machine.

____________________ ____ ____________

Cell Email Home

Signature:____

Signature

TODAY'S DATE: ______________

NAME: ________________________________ **DATE OF BIRTH:** ______________

What is the reason for this office visit? ______________________________

PAST MEDICAL HISTORY: (*please circle all that apply*)

Anxiety	Diabetes	Leukemia
Arthritis	GERD (Acid Reflux)	Lymphoma
Asthma	Hepatitis	Pacemaker/Defibrillator
Atrial Fibrillation	Hypertension	Radiation Treatment
Bone Marrow/Organ Transplant	HIV/AIDS	Seizures
COPD (Emphysema)	Hypercholesterolemia	Stroke
Coronary Artery Disease	Hyperthyroidism	Valve Replacement
Depression	Hypothyroidism	Kidney Disease

Cancer______________________________ Other______________________

Flu Vaccine: YES NO Pneumonia Vaccine: YES NO

Health Care Proxy/Living Will? YES NO

PAST SURGICAL HISTORY: (*please list*)

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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	

Other__________________________ Do you tan in a tanning salon? YES NO

Do you wear Sunscreen? YES NO If yes, what SPF? __________________

MEDICATIONS: (*please write all current medications*) ____________________

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ALLERGIES: (*please write all allergies*)

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SOCIAL HISTORY: (*please circle one*)

Cigarette Smoking: YES NO QUIT Alcohol Use: YES NO

Currently Pregnant or planning on pregnancy: YES NO Breast Feeding: YES NO

FAMILY HISTORY:

			If yes, which relative(s)
Do you have a family history of Melanoma?	Yes	No	______________
Do you have a family history of Bleeding Disorder?	Yes	No	______________
Do you have family history of heart disease?	Yes	No	______________
Do you have a family history of Diabetes?	Yes	No	______________

Any other family history: ____

PHARMACY NAME AND ADDRESS: ____

CONSENT TO TREAT, BENEFIT ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL POLICY

I, the undersigned, for myself or a minor child or another person for whom I authority to sign, hereby consent to medical care and treatment as ordered by a physician and certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to this physician practice site. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

The policy of Anderson Dermatology is that the patient has the ultimate responsibility for payment of his/her account. Payment is due a the time services are rendered unless specific arrangements have been made prior to treatment. Our office does participant with a number of insurance plans. Please contact your insurance company to verify participation. If we participate with your insurance carrier, you will be expected to pay your portion of the charge and/or a predetermined co-pay amount on the date of service, and we will file your insurance claim. We will allow a period of (45) days from the filing date for your carrier to process and pay your claim. If your claim has not been paid within that period, full payment of the charges, as well as any follow-up with the insurance company becomes your responsibility.

If we do not participate with your insurance carrier, we will file your claim as a courtesy, but you will be responsible for any out of network fees and co-insurance amounts at the time of the service.

If we refer you to a specialist or schedule procedures/tests, we will try to send you to a facility that participates with your insurance. Ultimately, it is your responsibility to contact the insurance company to confirm the provider is in the network and the procedure/test are authorized.

If you are not covered by an insurance plan, payment in full will be expected at the time of service. If this creates a financial hardship for you, please inform the receptionist before services are rendered so that satisfactory arrangements for payment can be made.

Patient Rights and Protections Against Surprise Medical Bills:
If you have private health insurance, there are protections that provide visibility to your planned medical charges and fees when requested. If you are uninsured or decide not to use your health insurance health care services, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit.

Patients who are uninsured or who choose not to utilize insurance coverage for medical services have the right to request a good faith estimate for the total expected costs prior to receiving care. For cash-pay patients, a breakdown of costs for any tests or procedures beyond the overall medical visit charge are shared at the time of the visit. You can request a paper copy of this estimate from our office at any time. We will also keep a copy on file in your patient chart for future reference if need be. If the bill you receive is at least $400 more than your good faith estimate, you can dispute the charges. You have 120 days from the date on your bill to do so. For questions or more information about your rights under the "No Surprises Act", visit www.cms.gov/nosurprises.

Signature of Patient or Legal Guardian	Printed Name of Patient or Legal Guardian	Date

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you and your rights with respect to your health information. You have the right to review our notice before signing this consent. As stated in our notice, the terms may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. The revised notice will also be posted in our waiting room.

Signature of Patient or Legal Guardian	Printed Name of Patient or Legal Guardian	Date