PATIENT INFORMATION

Name: (Mr., Mrs., Ms., Miss., Dr.) _____

DOB: _____ Sex: _____ Marital Status: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

e-mail: _____ Alternate e-mail: _____

Occupation: _____ If student (please check): FT ____ PT_____

Employer/School Name and Address: _____

_____

Parent/Guardian Name and Address if Patient is under 18 years old: _____

_____

Primary Care Physician: _____ Phone number: _____

Pharmacy name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Referred By: _____

Primary Insurance Information:

Insurance company: _____

Subscriber Name: _____ DOB: _____

Relationship to Subscriber: Self __ Spouse __ Dependent__ SSN: _____

Policy #: _____ Group #: _____

Secondary Insurance Information:

Insurance company: _____

Subscriber Name: _____ DOB: _____

Relationship to Subscriber: Self __ Spouse __ Dependent__

Policy #: _____ Group #: _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Address: _____

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Purpose of Visit

1. What is the nature of your skin problem? (Rash, Growth, General Skin Exam, etc.)

   _____

2. Have you had prior treatments for skin condition? If so, please explain.

   _____

3. Please list all medications that you are currently taking.

   _____

   _____

4. Are you allergic to any medication? Please list.

   _____

   _____

5. Are you currently pregnant? Yes ____ No ____ N/A____

Medical History

▢ Problems with bleeding	▢ Abdominal pain	▢ Heart attack
▢ Problems with healing	▢ Kidney or urinary problems	▢ Defibrillator
▢ Hay fever or other allergies	▢ Artificial Joints: Year ____	▢ Pacemaker
▢ Lupus/immunosuppression	▢ Anxiety/Depression	▢ Skin problems
▢ Heart problems	▢ Hepatitis: Type _____	▢ Skin cancer (See below)
▢ High blood pressure	▢ High Cholesterol	▢ Cancer: Type _____
▢ Diabetes	▢ Seizures	_____
▢ Thyroid Disease	▢ Stroke	▢ Other (List below)
		_____

Family history of Skin Cancer: _____

Social History

1. Do you drink alcohol? ▢ Yes ▢ No ▢ Daily ▢ Occasionally
2. Do you smoke? ▢ Yes ▢ No ▢ Quit ▢ Daily ▢ Occasionally Packs per day: _____

Do you have a living will or advance medical directive? ▢ Yes ▢ No

PAYMENT AGREEMENT

I request that payment of authorized benefits be made to Bala Dermatology for any services provided. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.

My name below verifies the accuracy of all of the above information including address, phone number, and medical history.

Patient or Authorized Designee Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that i have been provided the Practice Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and i have been given an opportunity to read the Notice.

I hereby authorize Bala Dermatology to use and disclose private health information about me to carry out treatment, healthcare operations and to secure payment from my insurance carrier (including Medicare, Blue Shield, Personal Choice, Aetna, Major Medical and all other private insurance carriers). I have the right to review the Notice of Practices prior to signing this consent. Further, I authorize my insurance carrier to make direct payment to Bala Dermatology. I realize I am responsible for deductible and copayments not covered by private insurance companies.

Signature _____ Date _____

Signature of Authorized Representative _____