Please complete these forms in order to ensure proper billing of your services.

PATIENT INFORMATION

Name ___________________________________ Date of Birth_____________________ Sex: F / M

Address _________________________________ Phone #1 _______________________ home / cell / work

City/St/Zip______________________________ Phone #2 _______________________ home / cell / work

Email Address ___________________________ Race____________________________________

Preferred Language________________________ Marital Status_____________________________

Social Security #__________________________ Ethnicity_________________________________

Employment Status: ☐ Employed ☐ Disabled ☐ Retired ☐ Student ☐ Not-Employed

Employer _______________________ Occupation __________________ Phone __________________

Emergency Contact________________________ Relation _____________ Phone____________________

REFERRAL INFORMATION

If you were referred by another physician, please indicate who. A letter will be sent to this doctor regarding your care in our office. If you are self-referred, but would like a letter sent to your primary care physician after each visit please put a check in the box next to your family doctor's name.

Referring Physician ____ Phone________________________

Address ____

Family Physician ______________________________ ☐ (Check for a letter to be sent) Phone________________________

Address ____

In accordance with your insurance carrier, it is your responsibility to know if a referral is required to see a specialist. If a referral is not present at the time of service, you may be financially responsible for any denied claims.

LAB PREFERENCE

We make every effort to send your specimen to a lab who is in-network with your insurance plan based on your carrier. However, we are not party to your individual contract with your insurance company. If there is a lab that your carrier requires you to use, it is your responsibility to notify us at the time of your procedure.

Please indicate your lab preference here. ____

✱ **SIGNED**____ **DATE**__________________

By signing, you agree that the information on this page is accurate.

Patient: ____ DOB: ______________

FINANCIAL RESPONSIBILITY

Who is financially responsible for the above named patient after insurance processes the claim?

Name_____________________________________ Relation to Patient ______________________

Address____________________________________ Phone #1 __________________ home / cell / work

City/St/Zip_________________________________ Phone #2 __________________ home / cell / work

Social Security #____________________________ Date of Birth ________________ Sex: F / M

I understand that I am financially responsible for all non-covered services, copays, coinsurance, and deductibles. **A service charge of 10% will incur if the bill is not paid within 60 days**

SIGNED____ **DATE**________________

INSURANCE INFORMATION

It is your responsibility to provide our office with your most current insurance information. If we do not participate in your insurance, you will be required to pay in full at the time of your visit.

PRIMARY Insurance Name__________________________________ Phone _________________

Address____

ID #____________________________________ Copay _____________ **Referral Required**: Y / N

Primary Insured Name ________________________________ Relation to Patient_______________

Date of Birth________________ Sex: F / M Social Security #_____________________________

SECONDARY Insurance Name________________________________ Phone _________________

Address____

ID #____________________________________ Copay _____________ **Referral Required**: Y / N

Primary Insured Name ________________________________ Relation to Patient_______________

Date of Birth________________ Sex: F / M Social Security #_____________________________

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Accent Dermatology. I also authorize the physician to release any information required to process any claims. I understand that I am responsible for knowing the benefits my insurance plan provides. I further understand that all copays are due at the time of service and I am also responsible to pay other amounts due. These amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account become delinquent.

SIGNED____ **DATE**________________

PATIENT MEDICAL HISTORY

Patient____ Date of Birth________________ Today's Date___________

Reason for today's visit: ____

Have you ever had dental anesthesia (Novocain) ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Past Medical History	YES	NO		YES	NO
Anxiety	☐	☐	Hyperthyroidism	☐	☐
Arthritis	☐	☐	Hypothyroidism	☐	☐
Asthma	☐	☐	Leukemia	☐	☐
Breast Cancer	☐	☐	Lung Cancer	☐	☐
Colon Cancer	☐	☐	Lymphoma	☐	☐
Depression	☐	☐	Pacemaker	☐	☐
Diabetes	☐	☐	Prostate Cancer	☐	☐
Hearing Loss	☐	☐	Radiation Treatment	☐	☐
Hepatitis	☐	☐	Seizures	☐	☐
HIV/Aids	☐	☐	Stroke	☐	☐
Hypertension	☐	☐			

Other____

Please list any surgeries you have had in the past ____

____

Skin History	YES	NO		YES	NO
Acne	☐	☐	Flaking/Itchy Scalp	☐	☐
Actinic Keratoses	☐	☐	Melanoma	☐	☐
Basal Cell Carcinoma	☐	☐	Precancerous Moles	☐	☐
Bleed Easily	☐	☐	Problems Healing	☐	☐
Blistering Sunburns	☐	☐	Psoriasis	☐	☐
Dry Skin	☐	☐	Squamous Cell Carcinoma	☐	☐
Eczema	☐	☐			

Other____

Do you develop skin rashes in reaction to: ☐ Medication ☐ Food ☐ Environment ☐ Bandages ☐ Neosporin

Do you wear sunscreen? ☐ YES ☐ NO If yes, what SPF? _______________

Family history of Melanoma? ☐ YES ☐ NO If Yes, which relative? ___________________________________

List all **medications** you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

____

____

____

Are you **allergic** to any medications? ☐ YES ☐ NO If yes, please list:___________________________________

____

Any other known allergies? ____

Social History

How often do you drink alcohol? ☐ Never ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Every Day Smoker ☐ Some Days Smoker

Do you use IV drugs? ☐ Yes ☐ No If yes, what? _________________ How Often? ________________________

Have been exposed to HIV/Aids? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No If yes, due date? ____________________

What is your occupation? ___________________________ Hobbies? ______________________________________

Patient: ____ DOB: ______________

This form must be filled out by a parent/guardian if the patient is under the age of 18

HIPAA PATIENT ACKNOWLEDGEMENT

We are required by law to maintain the privacy of protected health information and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please feel free to speak with our HIPAA Compliance Officer in person or by phone.

Your signature below is only acknowledgment that you understand that we maintain the privacy of your protected health information. If you would like a formal copy of our Notice of Privacy Practices, please ask for one at the front desk.

Print Name ____

* **Signature** ____ **Date** ___________

PERMISSION TO DISCUSS MEDICAL INFORMATION

I give permission for Dr. David High, Dr. Elyse Harrop, Dr. Rachel Klein, and the staff of Accent Dermatology to discuss my medical information including test results with the following friends or family members (If left blank, information will only be given directly to the patient or parent/guardian.)

Name: ____ Relation: _________________

Name: ____ Relation: _________________

Name: ____ Relation: _________________

<u>This authorization will stay in effect until the above patient terminates it.</u>

Print Name ____

* **Signature** ____ **Date** ___________