Welcome to Deerfield Dermatology Associates, Ltd.

Date:

PLEASE PRINT

PATIENT INFORMATION

Patient Name:______________________________________ SS #______ / _____ /________
Last Name First Name Middle Initial

Birthdate: ______ / ______ / _______ Age:_____ ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ other ____________________
Month Day Year

Preferred language: ____________________ Race: ☐ White ☐ Black ☐ Asian ☐ Latino Ethnic Background:______________________

Address: ____
City State Zip

Billing address: (if different from mailing address)____
City State Zip

Employed by: ______________________________________ Occupation: ____________________________________

Any other Family member or friend we have seen as a patient?____

IN CASE THE DOCTOR NEEDS TO REACH YOU

Home phone:(________)_________-____________ May we call your home? ☐ Yes ☐ No May we leave a message at home? ☐ Yes ☐ No

Work phone: (________)_________-____________ May we call your work? ☐ Yes ☐ No May we leave a message at work:? ☐ Yes ☐ No

Cell phone: (________)_________-____________ May we call your cell? ☐ Yes ☐ No May we leave a message on your cell? ☐ Yes ☐ No

May we leave messages with members of your household? ☐ Yes ☐ No Who may we leave message with? ___________________________

Email address: ____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

If same as patient, write: "Same"

____ SS #_______ /______ / ________
Last Name First Name Middle Initial

Relationship to patient: ________________________________ Birthdate: _____ /_____ / _____ Marital Status: ☐ Married ☐ Single ☐ other

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)

Primary insurance: ____ Secondary Insurance:____

PERSONAL MEDICAL HISTORY

Please check YES or NO for conditions you have or have had in the past.

Y N FAMILY HISTORY	Y N PERSONAL HISTORY	Y N	Y N	Y N
☐ ☐ Basal Cell Carcinoma	☐ ☐ Basal Cell Carcinoma	☐ ☐ Jewelry/Nickel Allergy	☐ ☐ Gout	☐ ☐ Kidney Disease
Relation:_______Date:______	Date:_________________	☐ ☐ Latex Allergy	☐ ☐ Cataracts	☐ ☐ Liver Disease
☐ ☐ Squamous Cell Carcinoma	☐ ☐ Squamous Cell Carcinoma	☐ ☐ Iodine Allergy	☐ ☐ Glaucoma	☐ ☐ Lung Disease
Relation:________Date:_____	Date:_________________	☐ ☐ Seasonal Allergies	☐ ☐ Colitis-diarrhea	☐ ☐ Mitral Valve Prolapse
☐ ☐ Melanoma Type:_________	☐ ☐ Melanoma Date:_______	☐ ☐ Photosensitivity	☐ ☐ Diabetes	☐ ☐ Multiple Sclerosis
Relation:________Date:_____	Type: _________________	☐ ☐ Allergic to local anesthetic	☐ ☐ Epilepsy	☐ ☐ Pacemaker
☐ ☐ Eczema	☐ ☐ History of skin disease	☐ ☐ Cold sores/Herpes	☐ ☐ AIDS/HIV Positive	☐ ☐ Prostate Problems/ Cancer
Relation:_________________	Type:_________________	☐ ☐ Anemia	☐ ☐ Heart disease	☐ ☐ Rheumatic Fever
☐ ☐ Asthma	☐ ☐ Actinic Keratosis	☐ ☐ Arthritis	☐ ☐ Heart surgery	☐ ☐ Stroke
Relation:_________________	☐ ☐ Precancerous Mole	☐ ☐ Bleeding disorder	☐ ☐ Hepatitis	☐ ☐ Tuberculosis
☐ ☐ Seasonal allergies	☐ ☐ Asthma	☐ ☐ Blood transfusion	☐ ☐ High Blood Pressure	☐ ☐ Venereal Disease
Relation:_________________	☐ ☐ Eczema	☐ ☐ Cancer Type:__________	☐ ☐ High Cholesterol	☐ ☐ Tobacco use qty:___ Quit___
☐ ☐ Psoriasis	☐ ☐ Hives/Urticaria	☐ ☐ Joint replacement:______	☐ ☐ Hyperthyroidism	☐ ☐ Alcohol use per week:______
Relation:_________________	☐ ☐ Food Allergies:_________	☐ ☐ Past surgeries:_________	☐ ☐ Hypothyroidism	☐ ☐ Other:_________________

CURRENT MEDICATIONS: ☐ NONE or list ____

____

PLEASE LIST ALL MEDICATION ALLERGIES: ☐ NONE ____

PHARMACY NAME:______________________________LOCATION:______________________PHONE NO.:________________________

Physician who referred you ___________________________________ Name of General Internist *(if different)*______________________________

Thank you for choosing our practice.

Please tell us how you heard about us: ☐ Friend ☐ Family Member ☐ Doctor's referral ☐ Yellow pages ☐ Internet ☐ Other ___________

HIPAA PATIENT CONSENT FORM

Required for medical offices by U.S. Federal Law, effective September 23, 2013

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Signing this form does not mean you have agreed to any special uses or disclosures of your health records. This form is an acknowledgment of the privacy practice not an authorization for use in processing claims or any information in regard to treatment/payment/operations (TPO).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.

This consent was signed by :	**Witness:**
____ Print Patient's name	____ Printed Name-Practice Representative
______________________________________ Signature of patient or representative	______________________________________ Signature
______________________________________ Relationship to Patient (If other than patient)	______________________________________ Date

INSURANCE AUTHORIZATION

I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for any balance due. I authorize the doctor or Insurance company to release any information required to process my claim.

Signature: ____Date: ______ / ______ / _______

FINANCIAL POLICY

I, the undersigned, acknowledge that I received a copy of Deerfield Dermatology Associates, Ltd. Financial Policy (*Eff. 01-01-2015*).

Signature: ____Date: ______ / ______ / _______

CREDIT CARD ON FILE:

Deerfield Dermatology uses a credit card merchant which will keep your information in our system where it remains secured and encrypted. For your convenience, you can provide a credit card (debit card, HSA card, FSA card) on file for payment of any or all future patient due balances.

Payment Authorization for Automatic Deduction

(Please have the receptionist scan your credit card in our system. Fill out the form below then sign and date.)

Last Four Digits of CC: _________ Expiration date: ________ Name on the card (*if different from the patient)*_______________________

Billing Address (*if different from patient's address)*: ____

I hereby authorize Deerfield Dermatology Associates, Ltd. to charge my credit card for any patient due balances. I understand that it is my responsibility to notify Deerfield Dermatology Associates, Ltd. of any changes to my credit card information.

Cardholder's Signature: ____Date: ______ / ______ / _______