DERMATOLOGY ASSOCIATES

History and Intake Form

Today's Date_____

Name: (Mrs)(Miss)(Mr)(Dr) _____ **SS#**: _____

Mailing Address: _____City and Zip _____

Email Address: _____

Phone: ( ) _____ ( ) _____ ( ) _____
HOME **CELL** **WORK**

Preferred Phone: ___Home ___Cell___ Work May we leave a detailed message? Yes No

Male/Female **Date of Birth**: _____ **Marital Status**: M / S / W /Other/Child

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander
Other: _____

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino
Decline to Specify

Language: _____

Employer:_____ **Retired? Previous Occupation**_____

Emergency Contact Name:_____ Phone:_____
Relationship:_____
Primary Care Doctor: _____ Phone:_____
Referring Doctor: _____ Phone:_____
Pharmacy: Name: _____
Street: _____ Zip code: _____Phone:_____
Insurance Company Name: _____
Subscriber Name: _____ Relationship:_____
Subscriber Date of Birth: _____ SS#_____

Reason for visit: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (benign prostatic hyperplasia)
Bone marrow transplant
Cancer: Type: _____
Coronary artery disease
Depression
Diabetes
End stage renal disease
GERD
Hearing loss
Hepatitis
Hypercholesterolemia
High Blood Pressure
HIV/AIDS
Leukemia/lymphoma
Pacemaker
Defibrillator
Seizures
Stroke
Thyroid Disease
None: _____
Other: _____

Past Surgical History: (please circle all that apply)

Appendix removed
Bladder removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast reduction
Breast Implants
Colectomy_____
Gallbladder removed
Coronary artery bypass
PTCA (Coronary Artery Stents)
Heart valve replacement_____
Heart Transplant
Knee (Right, Left, Bilateral)
Hip replacement (Right, Left, Bilateral)
Joint replacement (Right, Left, Bilateral)
Kidney surgery
Kidney transplant
Ovaries removed
Prostate surgery
Spleen removed
Testicles removed (Right, Left, Bilateral)
Hysterectomy_____
None
Other:_____
_____
_____

Skin Disease History: (please circle all that apply)

Acne
Actinic keratoses
Psoriasis
Basal cell cancer
Squamous cell cancer
Melanoma
Eczema
Rosacea
Seborrheic Dermatitis
Precancerous/Dysplastic moles
Psoriasis
Blistering sunburns
Other:_____

Do you wear sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)

_____ _____
_____ _____
_____ _____
_____ _____

Allergies: (Please enter all allergies)

_____ _____
_____ _____

Social History: (Please circle one)

Occupation: _____

Cigarette Smoking:

Never smoked
Former smoker-Quit _____ago
Smokes less than daily
Smokes daily

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

How often do you exercise?

Once a day
A few times a week
A few times a month
Never

What is your caffeine use?

Once a day
A few times a week
A few times a month
Never

Signature of Patient or Guardian: _____ Date:_____

PATIENT FINANCIAL POLICY

Thank you for choosing Dermatology Associates for your skin care needs. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.). Payment in full is due the day services are rendered.

Copayments and Deductibles
The patient is expected to present an insurance card at each visit. Payment of your copay, deductible and coinsurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered an act of fraud by your insurance plan. All copayments, deductibles and coinsurance, as well as past due balances, are due at the time of your appointment unless previous arrangements have been made with a billing coordinator. We accept cash, checks, MasterCard, Visa and Care Credit.

Insurance Claims
Insurance is a contract between you, your employer and your insurance company. In many cases, we are *not* a party of this contract. Not all services are covered by all contracts. We will bill your insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you are responsible for any portion of the charges above the usual and customary allowance.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive all billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balances
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to our collection agency or attorney and may result in possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs.

No Show Fee Policy
Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Patients must give a 24 hour advanced notice to cancel appointments. Failure to do so will result in a $25 fee charged to your account.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dermatology Associates for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance, or that my insurance company deems cosmetic in nature.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dermatology Associates to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records to Medicare. I request that payment of authorized benefits be made on my behalf.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or patient's parent or guardian **Date**

Name: _____ Date: _____

Please circle symptoms that apply to you:

Fever/Chills	Night Sweats	Unintentional weight loss
Headaches	Double vision	Blurry vision
Hearing loss	Ear pain	Runny nose
Hay fever/seasonal allergies	Sore throat	Mouth ulcers
Cough	Shortness of breath	Wheezing
Nausea	Vomiting	Diarrhea
Abdominal pain	Painful urination	Blood in urine
Joint aches	Muscle weakness	Seizures
Anxiety	Depression	Immunosuppression
Swollen joints	Bleeding Problems	Problems healing
Problems with scarring		

NONE OF THE ABOVE

Please circle all that apply to you:

Are you pregnant or planning a pregnancy

Premedication prior to procedures	History of MRSA
Pacemaker	Defibrillator
Blood thinners/Anticoagulation	Artificial joint within past two years
Artificial heart valve	Allergy to topical antibiotics
Allergy to adhesive	Allergy to lidocaine
Allergy to latex	Allergy to iodine
Allergy to shellfish	Sensitivity to epinephrine

NONE OF THE ABOVE

DERMATOLOGY ASSOCIATES
HIPAA

Protected Health Information or PHI is information that identifies who you are and relates to your past, present or future physical or mental health or condition, the provision of health care to you, or past, present or future payment for the provision of health care to you. PHI does not include information about you that is publicly available.

This office treats your PHI with the utmost confidence and care to protect your privacy and we adhere to the HIPAA (Health Insurance Portability and Accountability Act) guidelines. This notice briefly describes how medical information about you is protected, how it may be used and disclosed, and how you can get access to this information. The entire notice is available from the receptionist for you to review if you desire.

We restrict access to your PHI. We will only release your information with your signed authorization except in certain circumstances, i.e. as required by law.

I have read and understand the above.

_____ _____
Signature of Patient Date

PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

This office recognizes patients' rights. If you would like a copy of Patient's Rights and Responsibilities it is available from the receptionist.

_____ _____
Signature of Patient Date

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

The following person(s) may receive and discuss information regarding my healthcare:

_____ _____
Name Phone Number

_____ _____
Name Phone Number

_____ _____
Signature Date

DERMATOLOGY ASSOCIATES
Betsy Beers, M.D.
Tara Ezzell, M.D.
Susan D. Marchand, PA-C
Robyn Balkin, PA-C
350 NW 76 Drive, Suite A
Gainesville, FL 32607
352-332-4051

In order to accommodate our many requests for appointments with our physicians, many routine dermatologic problems may be seen by our physician assistants.

I understand that I will be seeing a licensed physician assistant whose work is directly supervised by Dr. Betsy Beers or Dr. Tara Ezzell. Dr. Beers/Dr. Ezzell will be available for consultation either in person, by conversation, or phone if the physician assistant or the patient feels this is necessary. Given scheduling limitations, however, face to face consultation with a physician may require an additional visit to the office.

I have read and agree to the above.

_____
Signature

_____
Date