PREMIER DERMATOLOGY & COSMETIC SURGERY

PATIENT INFORMATION SHEET

Patient Name: _____ **Date of Birth:** _____

Pharmacy: _____ **Pharmacy Phone Number:** _____

Reason(s) for Visit: (chief complaint)

_____

_____

_____

_____

Past Medical History: (Check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow transplant
- ☐ BPH (Enlarged Prostate)
- ☐ Cancer: _____
- ☐ Cholelithiasis (Gallstones)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis: _____
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Hypothyroidism (Underactive Thyroid)
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Nephrolithiasis (Kidney Stones)
- ☐ Seizures
- ☐ Stroke (CVA, TIA)
- ☐ **Other:** _____

Past Surgeries: (Check all that apply)

Appendix:
- ☐ Appendectomy

Bladder:
- ☐ Cystectomy (removal)

Breast:
- ☐ Lumpectomy: ☐ Right ☐ Left
- ☐ Mastectomy: ☐ Right ☐ Left

Colon:
- ☐ Colon Cancer Resection
- ☐ Diverticulitis
- ☐ Inflammatory Bowel Disease
- ☐ Gallbladder Removal

Heart:
- ☐ Biological Valve Replacement
- ☐ Coronary Artery Bypass Surgery (CABG)
- ☐ Defibrillator
- ☐ Heart Transplant
- ☐ Mechanical Valve Replacement
- ☐ Pacemaker
- ☐ PTCA (cardiac stents)

Joint Replacement:
- ☐ Hip: ☐ Right ☐ Left
- ☐ Knee: ☐ Right ☐ Left

Kidney:
- ☐ Dialysis
- ☐ Stone Removal
- ☐ Transplant
- ☐ Nephrectomy (removal)

Liver:
- ☐ Hepatectomy
- ☐ Transplant
- ☐ Shunt

Ovaries:
- ☐ Tubal Ligation

Pancreas:
- ☐ Pancreactectomy (removal)

Prostate:
- ☐ Prostatectomy (removal)
- ☐ TURP

Rectum:
- ☐ APR (abdominal perineal resection)
- ☐ Low Anterior Resection

Spleen:
- ☐ Splenectomy (removal)

Testicles:
- ☐ Orchiectomy (removal)

Uterus:
- ☐ Partial Hysterectomy
- ☐ Total Hysterectomy

Other: _____

Skin Disease: (Check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- **Other:** _____

Do you wear sunscreen? ☐ Yes ☐ No If Yes what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Medications: Please list all medications that you are currently taking and their dosage including over the counter and vitamins

Medication(s) Name:	

Allergies: (Check all that apply)

- ☐ No Known Drug Allergies
- ☐ Adhesive
- ☐ Codeine
- ☐ Environmental Allergies: _____
- ☐ Food Allergy: _____
- ☐ Iodine
- ☐ IV/Contrast Dye
- ☐ Latex
- ☐ Lidocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Topical antibiotic ointments

Other: _____

Social History: (Check all that apply)

Smoking Status: ☐ Current ☐ Former ☐ Never

Alcohol use: ☐ None ☐ less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more per day

Family History: (Check all that apply and write the family members relation; i.e. grandfather, grandmother, father, mother, sister, brother, son, daughter, aunt, uncle, niece, nephew)

- ☐ Adopted
- ☐ Non melanoma skin cancer: _____
- ☐ Melanoma: _____
- ☐ Asthma: _____
- ☐ Hay fever: _____
- ☐ Psoriasis: _____
- ☐ Eczema: _____
- ☐ Dermatitis: _____
- ☐ Allergies: _____

Other: _____

Alerts: (Check all that apply)

- ☐ Allergy to adhesive
- ☐ Allergy to latex
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ History of Melanoma
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning pregnancy

Patient/ Guardian Signature: _____

Date: _____

PDCS FINANCIAL AGREEMENT AND GENERAL POLICIES

Thank you for choosing PREMIER DERMATOLOGY & COSMETIC SURGERY (PDCS) for your family's dermatology and cosmetic surgical needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our Billing Department to allow us to help you manage your account in the most effective manner. Please be advised that your insurance coverage is determined by a contract between you and your insurance company. We will be glad to submit your claims for payment; however, the final responsibility for payment for services rendered rests with you, the patient, or the guarantor (person with financial responsibility for the account).

Please read our financial and general policies' below and sign to verify your receipt and understanding of this information.

1. We accept cash, check, VISA and MasterCard
2. If Medicare is your primary insurance, and your visit is for a medical condition that is generally covered or expected to be covered, we will gladly submit your insurance claim to Medicare. Your will be responsible for any co-insurance and/or deductible, as required by Medicare.
3. For all insurances, your co-payment, co-insurance, and self-payment amounts are due upon receipt of our bill. For office visit copays, you are required by your insurance contract to pay at the time of service.
4. If your insurance carrier requires a referral from your primary care provider for treatment, it is your responsibility to obtain the referral prior to your appointment. If you do not obtain and provide the referral within the time allowed by your insurance carrier, you will be financially responsible for all services rendered.
5. Returned checks are subject to a $30.00 service charge.
6. We are happy to provide any counseling on our billing practices; however, if your account is not paid within 90 days of the date of service, you will be responsible for full payment plus a monthly finance charge of 1.5% per month.
7. If we are participating with your insurance company, we are contractually required to adjust your account by a certain amount, which is known as a "contractual write-off". This does not mean you will not have a balance. We will bill you for balances as intended and directed by your insurance company.
8. Please understand that some service maybe OUT OF NETWORK with your insurance company, you will be responsible for the balance due.
9. If your account goes into "collection", then in addition to your outstanding balance, you will be responsible to pay a 25% fee charged by the collection agency as well as any subsequent legal or court costs.
10. Any Medical Necessity forms or letters required by your insurance company, or any communication outside the usual and customary forms required for billing or communication with other providers will be subject to a $25.00 administrative fee.
11. We will be happy to complete your disability forms which are subject to a $25.00 administrative fee.
12. As a courtesy to our patients relocating out of the area or changing providers for any other reason, we will be happy to supply you or your new provider with a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to a $25.00 administrative fee. This does not apply to necessary ongoing communication with your other providers, related to your ongoing care. Request for MEDICAL RECORD COPIES will take a minimum of 3 full business days to process.
13. I authorize payment of medical benefits for myself/dependents directly to PREMIER DERMATOLOGY & COSMETIC SURGERY for professional services and the release of medical information necessary to process insurance claims.
14. **We require 24 hour notice of cancellation of your appointment. Missed appointments or cancellations with less than 24 hours notice will be subject to a $30.00 missed appointment fee. Missed appointments can result in termination of physician-patient relationship.**
15. Patients arriving after their scheduled appointment time will be considered late for their appointment, and their appointment may be rescheduled as a result.
16. If PDCS does not have a contract (non-par)with my insurance carrier, I understand that I will be responsible for paying PDCS if my carrier does not pay.
17. If a patient has cancelled or no showed a surgical procedure, then we may require a deposit to reschedule the appointment. This deposit will be between $100 and $1,000, depending on the time allotted for the appointment. This deposit will be forfeited, if another cancellation or no show occurs.
18. No use of audio, video or recording devices are allowed in our suites or exam rooms without expressed written consent from PDCS.

X_____

PATIENT, GUARANTOR, OR PERSONAL REPRESENTATIVE'S SIGNATURE **DATE** **MRN**

The patient/guarantor has the responsibility to inform PDCS if the patient's contact information changes, i.e. phone number, address, and email.

Your signature on this page signifies that you acknowledge and accept the above information. This also serves as an assignment of insurance benefits to be paid directly to: PREMIER DERMATOLOGY & COSMETIC SURGERY.

PREMIER DERMATOLOGY & COSMETIC SURGERY

APEX MEDICAL CENTER
537 STANTON-CHRISTIANA ROAD, SUITE 107/207
NEWARK, DE 19713
TELEPHONE: (302) 633-7550 FAX: (302) 633-7556
www.premierdermde.com

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Premier Dermatology & Cosmetic Surgery. I hereby acknowledge receipt of Premier Dermatology & Cosmetic Surgery's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Premier Dermatology & Cosmetic Surgery's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

I, _____, hereby grant my permission for PREMIER DERMATOLOGY & COSMETIC SURGERY to inform the following individual/individuals of any and all results pertaining to my medical history and/or care:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

CONSENT FOR TREATMENT

A. I hereby request evaluation and treatment by a provider (physician, PA, or NP) of PREMIER DERMATOLOGY & COSMETIC SURGERY and/or their staff. This includes photographs needed for medical treatment and continuity of care.

B. The patient/guarantor has the responsibility to inform PDCS if the patient's contact information changes, i.e. phone number, address, and email.

C. I authorize payment of medical benefits for myself/dependent directly to PREMIER DERMATOLOGY & COSMETIC SURGERY for professional services.

D. For all services rendered to minor patients, the adult accompanying the patient is responsible for any payment due at the time of service.

E. I authorize the release of medical information necessary to process insurance claims.

X_____

(Signature of patient OR Responsible Party if a Minor) ***(Date)***

FOR MEDICARE PATIENTS ONLY:

Please sign below once or twice as applicable. You may complete insurance information or give cards to the receptionist to complete.

I request that payment of authorized **Medicare** and/or insurance benefits be made either to me or on my behalf to PREMIER DERMATOLOGY & COSMETIC SURGERY for any services furnished me by said physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

X_____ _____

(SIGNATURE OF BENEFICIARY) **(HIC CLAIM NUMBER)**

_____

(DATE)

SECONDARY INSURANCE FOR MEDICARE PATIENTS

I request that payment of authorized **Medigap** benefits be made either to me or on my behalf to PREMIER DERMATOLOGY & COSMETIC SURGERY. I authorize any holder of medical information about me to release to (below named **Medigap** insurer) any information needed to determine the benefits payable for related services.

X_____

(SIGNATURE OF BENEFICIARY)

_____

(MEDIGAP CARRIER)

_____

(MEDIGAP ADDRESS)

_____

(MEDIGAP POLICY NUMBER)

_____

(MEDIGAP POLICY HOLDER)