CHART #: _____ **PROVIDER**: _____

PLEASE COMPLETE THESE FORMS AND BRING THEM TO THE OFFICE AT YOUR SCHEDULED APPOINTMENT TIME*

PATIENT INFORMATION

Patient Name: _____

E-Mail Address: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Work Phone**: _____

Cell Phone: _____

Preferred phone number: ☐ Home ☐ Work ☐ Cell

DOB:_____ **SSN #:** _____ **Sex**: ☐ Male ☐ Female

Ethnicity:

- ☐ Hispanic or Latino
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Decline to Specify

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Other

Referred by: _____ **Primary Care Physician**: _____

Other family members that are patients: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

Resp. Party Name: _____

Address: _____

DOB: _____ **SSN #:** _____ **Sex:** ☐ Male ☐ Female

Home Phone: _____ **Work Phone**: _____

Employed by: _____ **Title**: _____

INSURANCE INFORMATION

Primary:

Insurance Company: _____

Subscriber Name: _____

Subscriber Address: _____

ID Number:_____ **Group Number**: _____

Group Name: _____

DOB: _____ **SSN #:** _____ **Sex:** ☐ Male ☐ Female

Home Phone: _____ **Work Phone**: _____

Employed by: _____ **Title**: _____

Patient Relationship to Subscriber:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Secondary:

Insurance Company: _____

Subscriber Name: _____

Subscriber Address: _____

ID Number:_____ **Group Number**: _____

Group Name: _____

DOB: _____ **SSN #:** _____ **Sex:** ☐ Male ☐ Female

Home Phone: _____ **Work Phone**: _____

Employed by: _____ **Title**: _____

Patient Relationship to Subscriber:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Financial Policy and Signature on File

Release of Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient/Responsible Party Signature: _____ **Date**: _____

Payment Policy

Medicare: We are participating providers of the Medicare Program. We will accept assignment on all claims. Patients are responsible for meeting their annual $166.00 Part B deductible and paying the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed.

Note: If you have recently changed or have new insurance, please let our staff know so that we may update our records and advise you if we are participating providers.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient/Responsible Party Signature: _____ **Date**: _____

Medicare Patients Only

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement.

> *I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its Intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment, Regulations pertaining to Medicare assignment of benefits policy.*

Signature as it appears on Medicare Card: _____ Date: _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

> *I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.*

Signature as it appears on Medigap Card: _____

Patient Name: _____ **DOB**: _____

Health History Form

Please list any **Medications**, **Vitamins and Over-the-Counter Medications** you are currently taking

Name	Strength	Frequency

Please list any allergies to medications: _____

_____

Please list any prior major illness, chronic conditions and/or injuries: _____

_____

Immunizations:	**Yes**	**No**	
Have you ever received a flu vaccine?	___	___	
Have you ever received a pneumonia vaccine?	___	___	
Review of Systems:			**Type**
Have you ever had skin cancer?	___	___	_____
Do you have a family history of skin cancer?	___	___	_____
Do you have a history of Hepatitis?	___	___	_____
Do you have HIV/AIDS?	___	___	_____
Do you bleed easily?	___	___	

Please indicate if you have any of the following conditions:

	Yes	No		Yes	No
Acne			Psoriasis		
Atypical Moles			Eczema		
Blistering Sunburns			Flaking/Itching Scalp		
Dry Skin			Hayfever/Allergies		

Please indicate if you have any of the following conditions:

	Yes	No	Year		Yes	No	Year
Heart Disease				Artificial Joint			
Thyroid Disease				Artificial Heart Valve			
Kidney Disease				Pacemaker			
Liver Disease				Defibrillator			
Diabetes				Cardiac Stents			
Organ Transplant				Leukemia/Lymphoma			
Stroke				Received Chemotherapy			
Heart Attack				Received Radiation			

Women:

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Social History:

Do you smoke? ☐ Current ☐ Former ☐ Never If yes, how much? _____

How often in a year do you consume more than (men) 5 drinks in a day or (women) 4 drinks in a day?

☐ None ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ >5

Do you have a living will? ☐ Yes ☐ No

Who is your Emergency Contact who is able to make medical decisions?_____

Phone Number: _____

It is the policy of this practice to import your medications from **Surescripts**, the national database of prescription medications

Signature:_____ Date: _____

New Patient Consent to Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my healthcare, Dermatologic Surgery Center of Northeast Ohio, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided upon request a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that the Dermatologic Surgery Center of Northeast Ohio, Inc is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that the Dermatologic Surgery Center of Northeast Ohio, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should the Dermatologic Surgery Center of Northeast Ohio, Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether by US mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such a disclosure for these permitted uses, including disclosures via fax.

I understand and ☐ Accept or ☐ Decline the terms of this consent.

_____
Patient's Signature

_____
Date

_____ Yes _____ No
I give my consent to leave any biopsy or test results on my answering machine, voicemail, or with a family member.

The Dermatologic Surgery Center of Northeast Ohio
1133 Medina Rd, Suite 100
Medina, OH 44256
p. 330.239.4350

Smoking Notification

Patient Name: _____ DOB: _____

I understand that smoking interferes with the circulation of the blood to the skin and that complications can result from insufficient circulation, including but not limited to, delayed wound healing, infection, excessive scarring and skin necrosis (skin decay).

I understand that I should not smoke for at least 3 days prior to and 3 days after my surgery. I also understand that I should not use nicotine gum, patches or chewing tobacco for this period as this is just as harmful as actively smoking cigarettes.

Please call the office with any questions or concerns at 330.239.4350

☐ I am not a smoker

☐ I am a smoker and I understand the risks of smoking in conjunction with my surgery

_____ _____
Signature Date