Patient Name: _____

Date of Birth:_____

Premier Dermatology & Cosmetic Surgery

Information Sheet

Pharmacy: _____ Phone: _____

Family Physician:_____ Phone: _____

Cardiologist: _____ Phone: _____

Ophthalmologist: _____ Phone:_____

Dermatologist: _____ Phone: _____

Past Medical History:

(Check all that apply)

- □ Adrenal Insufficiency
- □ Anemia/Thalassemia
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrilation (irregular Heartbeat)
- □ Auto- Immune Disease
- □ Bipolar Disorder
- □ Blood Clotting Disorder
- □ BPH
- □ Breast Cancer
- □ **Cold Sores**
- □ Colon Cancer
- □ **Congestive Heart Failure**
- □ COPD
- □ Coronary Artery Disease
- □ Deep Vein Thrombosis
- □ Depression
- □ Diabetes
- □ Easy Bruising
- □ End Stage Renal Disease
- □ GERD
- □ **Glaucoma**
- □ Head Trauma
- □ Hearing Loss
- □ **Heart Attack**
- □ **Heart Murmur**
- □ Hepatitis
- □ Hypertension
- □ HIV/AIDS
- □ Hypercholesterolemia
- □ Hyperthyroidism
- □ Hypothyroidism
- □ **Injury to Nose**
- □ **Keloids/Unusual Scarring**
- □ **Leukemia**
- □ **Liver Disease**
- □ Lung Cancer
- □ **Lung Disease**
- □ Lupus
- □ Lymphoma
- □ Malignant Hypertension
- □ Mental Health Hospitalization
- □ **Mitral Valve Prolapse**
- □ Neuromuscular Disorder
- □ **Pacemaker**
- □ Paralysis
- □ Pneumothorax
- □ Prostate Cancer
- □ Pulmonary Embolism
- □ Radiation Treatment
- □ Renal Disorder
- □ Rheumatoid Arthritis
- □ Seizures
- □ Severe Reaction to Anesthesia
- □ **Shingles**
- □ **Sinus Conditions**
- □ **Sleep Apnea**
- □ **Spinal/Back Disorder**
- □ **Stomach Problem/Ulcer**
- □ Stroke
- □ Trauma
- □ Vascular Heart Disease
- □ Vision Loss
- □ Other _____

Past Surgeries:

(Check all that apply and date of procedure)

Abdomen:

- □ Laparoscopy
- □ Laparotomy

Abdominal Wall:

- □ Hernia Repair- Left Femoral
- □ Hernia Repair- Left Inguinal
- □ Hernia Repair- Right Femoral
- □ Hernia Repair- Right Inguinal
- □ Hernia Repair- Umbilical
- □ Hernia Repair- Ventral
- □ **Appendix** (Appendectomy)
- □ **Bladder** (Cystectomy)

Brain:

- □ Surgery for Cancer
- □ Surgery for Trauma

Breast:

- □ Breast Biopsy
- □ Lumpectomy- Both breasts
- □ Lumpectomy- Left breast
- □ Lumpectomy- Right breast
- □ Mastectomy- Both breasts
- □ Mastectomy- Left Breast
- □ Mastectomy- Right Breast
- □ **Cesarean Section**

Colon:

- □ Colon Cancer Resection
- □ Diverticulitis
- □ Inflammatory Bowel Disease
- □ Colostomy
- □ **Esophagus-** Esophagectomy
- □ **Gallbladder**

Heart:

- □ Biological Valve Replacement
- □ Coronary Artery Bypass Surgery
- □ Heart Transplant
- □ Mechanical Valve Replacement
- □ PTCA

Joint Replacement:

- □ Hip- Both
- □ Hip- Left
- □ Hip- Right
- □ Knee- Both
- □ Knee- Left
- □ Knee- Right

Kidney:

- □ Biopsy
- □ Stone Removal
- □ Transplant
- □ Nephrectomy

Liver:

- □ Hepatectomy
- □ Transplant
- □ Shunt

Lung:

- □ Left Lower Lobectomy
- □ Left Pneumonectomy
- □ Left Upper Lobectomy
- □ Right Lower Lobectomy
- □ Right Middle Lobectomy
- □ Right Pneumonectomy
- □ Right Upper Lobectomy

Ovaries:

- □ Endometriosis
- □ Ovarian Cancer
- □ Ovarian Cyst
- □ Tubal Ligation
- □ **Pancreas**- Pancreactomy

Prostate:

- □ Biopsy
- □ Cancer
- □ TURP

Rectum:
- □ APR
- □ Low Anterior Resection

Skin:
- □ Basal Cell Carcinoma
- □ Melanoma
- □ Skin Biopsy
- □ Squamous Cell Carcinoma
- □ **Small Bowel Resection**
- □ **Spine Surgery**
- □ **Spleen**- Splenectomy

Stomach:
- □ Gastrectomy
- □ Gastostomy
- □ **Testicles**- Orchiectomy

Uterus:
- □ Fibroids
- □ Uterine Cancer
- □ Cervical Cancer
- □ **Other** _____

Skin Disease:

(Check all that apply)

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

Do you wear sunscreen? □ Yes □ No If Yes what SPF? _____
Do you tan in a tanning salon? □ Yes □ No

Plastic Surgery History:

(Check all that apply)

Abdomen:
- □ Abdominal Wall Reconstruction
- □ Abdominoplasty

Body Contouring:
- □ Brachioplasty
- □ Liposuction
- □ Lower Body Lift
- □ Thigh Lift
- □ Upper Body Lift

Breast:
- □ Augmentation
- □ Lift (Mastopexy)
- □ Reconstruction
- □ Reduction
- □ Correction of Nipple Inversion
- □ Implant Removal
- □ Nipple Reconstruction
- □ **Burn Wound Reconstruction**
- □ **Carpal Tunnel Release**
- □ **Chemical Peel**

Cleft:
- □ Lip Repair
- □ Palate Repair
- □ **Cubital Tunnel Release**
- □ **Decubitis Ulcer Reconstruction**

Ears:
- □ Reconstruction
- □ Earlobe Repair
- □ Otoplasty

Face:
- □ Blepharoplasty
- □ Brow Lift
- □ Cheek Augmentation
- □ Chin Augmentation
- □ Facelift
- □ Lefort Osteotomy
- □ Lower Blepharoplasty
- □ Orbital Floor Fracture
- □ Repair of Craniosynostosis
- □ Upper Blepharoplasty
- □ **Hair Restoration**
- □ **Laser Hair Removal**
- □ **Liposuction of Face**
- □ **Liposuction of Neck**

Nose:
- □ Rhinoplasty
- □ Septoplasty
- □ **Scar Revision**
- □ **Other** _____
- □ **None**

Medications:

Please list all medications that you are taking and their dosage

Name:	

Allergies:

Please list all drug, anesthetic (numbing medication), tape, latex, iodine, or food allergy

Chief Complaint:

Please briefly describe why you are here today and list any medication that you have tried for your complaint

_____

_____

Social History:

(Check all that apply)

Smoking Status: □ Current □ Former □ Never □ Vaping
- □ Start Date: _____
- □ Quit Date: _____

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

□ Occupation_____

Family History:

(Check all that apply and write the family members relation)

- □ Non melanoma skin cancer _____
- □ Melanoma _____
- □ Asthma _____
- □ Breast Cancer _____
- □ Psoriasis _____
- □ Eczema _____
- □ Dermatitis _____
- □ Acne _____
- □ Malignant Hyperthermia_____
- □ Other _____

Review of Systems:

(Do you have any of the following problems or conditions? Check **Yes** or **No**)

Constitutional:

Fatigue	□Yes □No
Fever	□Yes □No
Weight loss or gain	□Yes □No
Night sweats	□Yes □No

HEENT:

Hearing Loss	□Yes □ No
Difficulty Breathing Through Nose	□Yes □No
Nose Bleeds	□Yes □No
Sinus Problems	□Yes □No
Blurred vision	□Yes □No
Double vision	□Yes □No
Dry Eyes	□Yes □No
Itching/Irritation of Eyes	□Yes □No
Dentures?	□Yes □No
Glasses?	□Yes □No

Respiratory:

Frequent Cough	□Yes □No
Shortness of Breath	□Yes □No
Wheezing	□Yes □No

Cardiovascular:

Chest Pain	□Yes □No
Leg Swelling	□Yes □No
Palpitations	□Yes □No

Gastrointestinal:

Abdominal pain	□Yes □No
Bowel habits change	□Yes □No
Indigestion/Heartburn	□Yes □No
Nausea/Vomiting	□Yes □No

Genitourinary:

Urinary frequency	□Yes □No
Painful Urination	□Yes □No
Nighttime Urination	□Yes □No

Integumentary:

Hair Loss	□Yes □No
Rashes	□Yes □No
Sores	□Yes □No

Neurological:

Dizzy Spells	□Yes □No
Numbness/Tingling	□Yes □No
Weakness/Paralysis	□Yes □No
Headaches	□Yes □No
Seizures	□Yes □No
Tremors	□Yes □No

Psychiatric:

Depression	□Yes □No
Mood Swings	□Yes □No
Recent Crisis	□Yes □No
Psychiatric Treatment	□Yes □No

Endocrine:

Cold Intolerance	□Yes □No
Heat Intolerance	□Yes □No
Excessive Thirst	□Yes □No
Excessive Sweating	□Yes □No

Musculoskeletal:

Back Pain	□Yes □No
Muscle Weakness	□Yes □No
Leg Pain	□Yes □No
Movement Limitation	□Yes □No

Hematologic/Lymphatic:

Easy Bruising	□Yes □No
Spontaneous Bleeding	□Yes □No
Blood Clotting	□Yes □No

Allergic/Immunologic:

Environmental Allergies	□Yes □No

Cautions:

(Check all that apply)

- □ Accutane Use
- □ 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
- □ History of Melanoma
- □ Malignant hyperthermia
- □ MRSA
- □ Pacemaker
- □ Premedication prior to procedures
- □ Rapid heartbeat with epinephrine
- □ Pregnancy or planning pregnancy

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. You 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 services may be 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.

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)

PREMIER DERMATOLOGY
& COSMETIC SURGERY

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient or the legal guardian of a patient of Premier Dermatology & Cosmetic Surgery. I acknowledge receipt of Premier Dermatology & Cosmetic Surgery's Notice of Privacy Practices.

I grant 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

_____ _____

Print Patient's Name Date

_____

Print Name of Legal Guardian