PATIENT INFORMATION

Name: ______________________________________ Date of Birth: ____________

Last First M.I.

Mailing Address: ____

Number, Street, Apartment Number

____

City State Zip

Home Phone: _______________ Work: _______________ Cell: _________________

Preferred Pharmacy: ____

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Name of your insurance company: ____

Policy Holder: ________________________________ DOB: ____________________

Person to notify in case of an emergency: ___________________ Phone: __________

(Please list a person not living in your home)

Primary Care Doctor: ____

Referring Doctor: ____

(If different from your Primary Care Doctor)

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If patient is a minor, please enter responsible party information. (Note: We do not bill absent parents. The adult presenting the minor for care is the responsible party).

Name: ____ SS#: ____________

Last First M.I.

Mailing Address: ____

Number, Street, Apartment Number

____

City State Zip

Home Phone: ________________ Work: _________________ Cell: __________________

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Medical History

Patient Name:______________________ Date of birth:______________________

Referring MD:______________________ Primary MD:______________________

Reason for today's visit:______________________

Are you allergic to any medications: ◯ Yes ◯ No If yes, list:______________________
Do you suffer from seasonal allergies: ◯ Yes ◯ No

List all medications you are currently taking: (include over-the-counter medications and vitamins)______________________
____
____

Occupation:______________________ Marital Status: ______________________
Race: White African American American Indian Asian Native Hawaiian Other________ Decline to answer

Do you have, or have you ever had any of the following conditions or diseases: (Please circle Yes or No)

Condition			Condition		
Abnormal Bleeding/Hemophilia	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No
Arthritis	Yes	No	Hepatitis or Yellow Skin	Yes	No
Artificial Joints	Yes	No	High Blood Pressure	Yes	No
Bronchitis	Yes	No	HIV/AIDS	Yes	No
Cancer	Yes	No	Irregular Heartbeat	Yes	No
If Yes, what type:			Liver Disease	Yes	No
Chest Pain	Yes	No	Mitral Valve Prolapse	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No
Drug Dependency	Yes	No	Rheumatic Fever	Yes	No
Alcohol Dependency	Yes	No	Personal History of Skin Cancer	Yes	No
Epilepsy, Seizures, Fainting Spells	Yes	No	If Yes, what type:		
(Circle which condition)			Specific Skin Diseases	Yes	No
Glaucoma	Yes	No	If Yes, what type:		
Kidney Disease	Yes	No	Thyroid Disease	Yes	No
Heart Attack	Yes	No	Emphysema/COPD	Yes	No

Family History of skin cancer	Yes	No	Family History of atypical moles	Yes	No
If yes, what type:			If yes, what type:		
which relative:			Which relative:		

Please answer the following:

Do you smoke	Yes	No	Do you drink alcohol	Yes	No
Number of packs per day:			Number of drinks per day:		
Have you ever had a bad reaction to an Anesthetic	Yes	No	(Women) Are you pregnant	Yes	No
			Are you nursing	Yes	No
Do you need antibiotics before dental procedures	Yes	No	Are you trying to become pregnant	Yes	No

Skin:

Have you ever had blistering sunburns	Yes	No	Do you frequent tanning salons	Yes	No
Do you regularly use sunscreen	Yes	No	Do you, or have you ever had an outdoor occupation	Yes	No
Acne patient's only:			When you are exposed to the sun, do you: (circle one)		
Have you taken Accutane (oral acne medicine) in the last year	Yes	No	Tan only Tan and burn Burn N/A		

List any surgical procedures you have had in the last six months:______________________
____

List any other disease or condition we should know about:______________________
____

PATIENT FINANCIAL POLICY
Pittsford Dermatology

This office has contracts with many managed care plans. Please check with our reception staff to determine whether your plan is one of these.

Please be aware that verification of a contract, benefits or a referral authorization does not guarantee payment. Reimbursement for services rendered is determined once the claim is submitted and can be denied.

If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible (any deductibles, copays, percentages or non-covered services) is required at the time of the service.

If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service.

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

48 hours' notice is required to cancel or reschedule an appointment. Failure to give 48 hours' notice may result in a $25 fine for a regular appointment, and a $50 fine for a surgical appointment. Such fees must be paid before another appointment will be scheduled.

In the event that you do not pay when fees are due, you will be responsible for all collections costs and or any attorney's fees until the balance is paid in full.

For your convenience in paying, this office accepts Master Card and Visa in addition to cash and checks. A $25 fee will be levied for returned checks.

I certify that I have read the financial policy of Pittsford Dermatology, and agree to abide by the policy.

______________________________________ ______________________
Signature Date

ASSIGNMENTS OF BENEFITS

ALL INSURANCES EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Pittsford Dermatology. I authorize Pittsford Dermatology to provide to my insurance company, any information necessary to process claims for services rendered to me.

____ ______________________
Signature Date

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this 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 apply.

____ ______________________
Signature as it appears on Medicare Card Date

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy or other 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 my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

____ ______________________
Signature as it appears on MEDIGAP Card Date

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? ☐ Yes ☐ No

Are you covered by any other insurance that makes Medicare secondary? ☐ Yes ☐ No

HIPAA Authorization

Pittsford Dermatology is committed to protecting the privacy of our patients' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our patients' about those measures.

Please complete the section below on how Pittsford Dermatology may use and disclose your protected health information.

You may authorize any of the following:

May we contact or leave a message pertaining to medical/appointment information:

Home Phone?	○ Yes	○ No	
Cell Phone?	○ Yes	○ No	
Work phone?	○ Yes	○ No	○ N/A
By mail?	○ Yes	○ No	
With another person?	○ Yes	○ No	

If yes, whom:_______________________ Relationship:____________________