HARRIS DERMATOLOGY
H. ROSS HARRIS, M.D., P.A.
PATIENT INFORMATION

2018

Date Completed:_____

A. PATIENT INFORMATION

Name:_____
Last First MI

D.O.B.: ____/____/____ Age:_____ Sex:___M___ F SS#:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other_____ ☐ Decline

Preferred Language: ☐ English ☐ Spanish ☐ Creole ☐ Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Local Address:_____
Street Apt # City State Zip

What is the best phone number to reach you at: 1) _____ 2) _____

E-mail:_____

Northern or other address: (if applicable)_____
Street Apt # City State Zip

Est. Dates when you are in our area:_____ Northern Phone:(____)_____
Area Code

Are you Employed: Full Time_____Part Time_____Retired_____Not Employed_____

Employer Name:_____ Phone #:_(____)_____

Responsible Party (if different from patient): Name:_____D.O.B.:_____

Address:_____

B. BILLING AND INSURANCE INFORMATION

Primary Insurance:_____

Insured's Name:_____D.O.B.:____/____/____ID#:_____
Relationship to Insured: ( ) Self ( ) Spouse

Secondary Insurance:_____

Insured's Name:_____D.O.B.:____/____/____ID#:_____
Relationship to Insured: ( ) Self ( ) Spouse

Name of Laboratory, if any, required by your insurance?_____

C. OTHER INFORMATION

In case of emergency, who should be notified?_____Phone:_(____)_____
Area Code

If you answer yes to either of the questions below, please notify receptionist before your appointment:

Do you have medical assistance through welfare or state-aid (Medicaid)? ( ) YES ( ) NO

Are you coming to our office due to an employment related illness (Worker's Comp)? ( ) YES ( ) NO

HARRIS DERMATOLOGY

H. ROSS HARRIS, MD, PA

FINANCIAL POLICY

Patient Name _____ Today's Date ____ / ____ / ____

A. RELEASE OF INFORMATION:

I authorize the release of medical information to other physicians or qualified health care professionals and as necessary to insurance companies to process insurance claims, insurance applications and other administrative medical requests. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____

B. OTHER INSURANCE:

1. **BC/BS - Participating Plans:** Patients are responsible for paying an estimated deductible, copayment, coinsurance and any non-covered and/or cosmetic service, at the time of service. Once BCBS has processed the claim, the patient may still have an outstanding balance requiring immediate payment.

2. **Non-Participating Insurance Carriers:** Patients who are covered by private and/or commercial plans for which H.Ross Harris, MD, PA health care professionals are not providers will be required to pay an estimated balance at the time of service. You will be provided with a properly coded statement for you to submit to your insurance company for reimbursement. It is recommended to keep a copy for your files. You are responsible for any remaining balance due regardless of your insurance company's reimbursement to you.

Patient or Responsible Party Signature: _____

C. COLLECTION COSTS:

1. I further understand I am fully responsible for providing H.Ross Harris, MD, PA with new insurance information immediately, and realize I may be billed in full for any medical services if I fail to report changes of insurance coverage.

2. I hereby assume responsibility to pay the cost of all services provided by H.Ross Harris, MD, PA; realizing the initial quote and payment is only an estimate of my total costs.

The undersigned agrees to pay charges arising from the medical treatment of the above patient, as well as any and all costs of collection for any charges. This cost includes attorney fees, court costs, collection agency fees and any and all expenses occurred in the collection of any monies due.

Patient or Responsible Party Signature: _____

HARRIS DERMATOLOGY
H. Ross Harris, M.D., P.A.
Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If YES, list: _____
List all Medications with dosage you are currently taking including over the counter medications, vitamins and supplements:
❑ None ❑ Not Available ❑ See List

_____

_____

LUNGS:	YES	NO
Emphysema	❑	❑
Asthma	❑	❑
O_2 Dependent/Use	❑	❑
VASCULAR:		
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Pacemaker	❑	❑
Defibrillator	❑	❑
Phlebitis	❑	❑
Mitral Valve Prolapse	❑	❑
Heart Valve Replacement	❑	❑

Other, Systemic:	YES	NO
Diabetes	❑	❑
Dialysis (Past or present)	❑	❑
Kidney_____	❑	❑
Thyroid_____	❑	❑
Bladder_____	❑	❑
Stomach_____	❑	❑
Bowel_____	❑	❑
Hepatitis	❑	❑
Glaucoma	❑	❑
Arthritis/Joint Deformity	❑	❑
Convulsions, Epilepsy, or Seizures	❑	❑
Fainting	❑	❑
Cold Sores/Fever Blisters/Herpes Simplex Virus	❑	❑
If Yes, Frequency_____		

List any other disease or condition we should know about including malignancies/cancer: _____

_____

List surgical procedures you have had in the last 6 months: _____
Have you been told you need to take antibiotics before routine dental cleanings or surgical procedures? ❑ Yes ❑ No
If yes, what do you take and why? _____

Who is your Primary Care Physician: _____ Pharmacy of Choice: _____
Did a physician refer you to our practice? ❑ Yes ❑ No If yes, whom? _____
Do you see any specialist? ❑ Oncologist ❑ Allergist ❑ Cardiologist ❑ Nephrologist
❑ Rheumatologist ❑ Orthopedic Surgeon ❑ Other: _____

Skin: When you are exposed to sun do you: ❑ Tan only ❑ Tan and burn ❑ Burn
Have you ever had skin cancer? ❑ Yes ❑ No
Has anyone in your family had skin cancer? ❑ Yes ❑ No If YES, Who? _____
Do you have a history of any specific skin diseases? ❑ Yes ❑ No
If yes, please list: _____

Please answer the following questions:

A. Tobacco use: ❑ Current Smoker (how much)_____ ❑ Former Smoker (when quit)_____ ❑ Never Smoker
B. Do you drink alcohol? ❑ Yes ❑ No If Yes, _____ drinks per day
C. Do you bleed easily? ❑ Yes ❑ No
D. Do you have artificial joint(s) ❑ Yes ❑ No If Yes, which joint _____ When _____
E. (Women) Are you pregnant? ❑ Yes ❑ No
F. (Women) Are you breast feeding? ❑ Yes ❑ No
G. What is your occupation? _____
H. What are your hobbies? _____

Completed by: ❑ Patient
❑ Caregiver _____ Initials
❑ Medical Assistant

_____
Signed by Physician Date

_____
Reviewed by Date

HRH CL 008 11/14 Chart # _____

HARRIS DERMATOLOGY

H. ROSS HARRIS, M.D.

DIPLOMAT OF THE AMERICAN BOARD OF DERMATOLOGY

Additional Medical History

Patient: _____ Date: _____

Have you had the Flu Vaccine? ❑ Yes ❑ No If yes, when: _____

Have you had the Pneumonia Vaccine? ❑ Yes ❑ No If yes, when: _____

Do you have Diabetes? ❑ Yes ❑ No If yes, when was your last:

Primary Care Physician exam, date _____

Endocrinologist exam, date _____

Podiatrist exam, date _____

Eye exam with dilation, date _____

Men and women (65 years old and older): Have you had a fall or difficulty with walking or balance within the past year?
❑ Yes ❑ No

Do you have an Advance Care Plan such as; Living will, DNR orders, Durable Power of Attorney, or health care proxy?
❑ Yes* ❑ No **If yes, please provide a copy for our records.*

Do you have a surrogate decision maker (someone you would like to have make decisions on your behalf if you do not have decision-making capacity) ❑ Yes ❑ No If yes, who: _____

If you drink alcohol: How many times in the past year have you had:

Men (64 years old or younger) 5 or more drinks per day? _____ times.

Men (65 years old or older) 4 or more drinks per day? _____ times.

Women (of all ages) 4 or more drinks per day? _____ times.

When was your last:

Men and women (50-75 years old) Colonoscopy, date _____ ❑ Never

Men and women (50-75 years old) Sigmoidoscopy, date _____ ❑ Never

Women (21-64 year old) Pap smear, date _____ ❑ Never

Women (50-74 years old) Mammogram, date _____ ❑ Never

HARRIS DERMATOLOGY

H. ROSS HARRIS, M.D., P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I,_____ ,have reviewed and been given an opportunity to obtain a copy of H. Ross Harris, M.D., P.A.'s Notice of Privacy Practices. I understand that copies of the Notice of Privacy Practices are posted at the office of H. Ross Harris, M.D., P.A. and that I may, at any time, request a copy of the notice.

_____ _____

Signature of Patient/Legal Representative Date

If you are the legal representative of the patient, please provide the following information:

Your Name:_____

Your Address:_____

Your Phone #:_____

Nature of Legal Relationship: _____

(i.e. parent or legal guardian of patient under the age of 18, legal guardian, have power of attorney for patient, etc.)

CONSENT TO DISCLOSE OR DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

H. Ross Harris, M.D., P.A. will maintain the privacy of your Protected Health Information as required by law and by the Notice of Privacy Practices currently in effect. Are there other people besides yourself and in addition to those allowed by law to whom you authorize H. Ross Harris, M.D., P.A. to disclose Protected Health Information or with whom you authorize H. Ross Harris, M.D., P.A. to discuss your Protected Health Information? If so, please provide the following information:

Name:_____Relationship: _____

Name:_____Relationship:_____

Please state any limitations or restrictions on your Consent to Release Protected Health Information to the above-named individuals:_____

_____

Please note that you may modify or revoke this consent in writing at any time unless H. Ross Harris, M.D., P.A. is acting or has acted in reliance on an existing consent from you.

_____ _____

Signature Date

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____