HARRIS DERMATOLOGY

2018

PATIENT INFORMATION

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

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MEDICARE FINANCIAL POLICY

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

A. RELEASE OF INFORMATION:

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

Patient or Responsible Party Signature: _____

B. MEDICARE INFORMATION:

1. Harris Dermatology is a participating provider of the original Medicare program. Harris Dermatology accepts assignment for all original Medicare claims and will file with secondary/supplemental carriers as a courtesy service. Patients are responsible for paying their annual deductible, the 20% coinsurance and any non-covered services at the time of service. In the event the secondary insurance does not pay within **30 days** the patient will be balance billed.

2. I authorize Harris Dermatology to release to the Social Security Administration and Center for Medicare & Medicaid Services or its intermediaries or carrier any information needed for this or a related medical 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 apply.

3. Harris Dermatology does **NOT** participate in Medicare Advantage Plans, Medicare HMOs, or other Medicare replacement products. Harris Dermatology will **NOT** file to any of these plans. It is the patient's responsibility to notify Harris Dermatology of any changes to your original Medicare plan.

Signature as it appears on MEDICARE Card: _____

Harris Dermatology is required to keep a separate signature on file if you have a **Supplemental** (a.k.a. Medigap) policy in which your original Medicare carrier automatically "crosses over," however; Harris Dermatology is not responsible for verifying your supplemental insurance coverage.

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

Signature as it appears on Supplemental (Medigap) Card: _____

C. COLLECTION COSTS:

1. I further understand that I am fully responsible for providing Harris Dermatology with new insurance information immediately, and realize I may be billed in full for any medical services if I fail to do so.

2. I hereby assume responsibility to pay the cost of all services provided by Harris Dermatology; realizing that 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 of the charges. This cost includes attorney fees, court costs, collection agency fees and any and all expenses that occur in the collection of any monies due.

Patient or Responsible Party Signature: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I,_____,have reviewed and been given an opportunity to obtain a copy of Harris Dermatology's Notice of Privacy Practices. I understand that copies of the Notice of Privacy Practices are posted at the offices of Harris Dermatology 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

Harris Dermatology 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 Harris Dermatology to disclose Protected Health Information or with whom you authorize Harris Dermatology 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 Harris Dermatology 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:_____

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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

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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

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MEDICARE SECONDARY COVERAGE DETERMINATION

PATIENT NAME: _____ DATE :_____

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does not apply to you, please check NO.

YES	NO	
		Do you work in a company which has more than 20 employees and have coverage through the insurance at that job?
		Does your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
		Are you covered by an HMO/PPO which makes Medicare secondary?
		Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
		Are you eligible for any benefits under the Federal Black Lung Program?
		Are you coming to this office for illness, accident or injury that is the result of an automobile accident?
		Are you coming to this office due to disability coverage?
		Are you covered by the Federal End Stage Renal Disease Program?
		Are you presently receiving Workers' Compensation?
		Is the illness or injury you are coming to this office for the result of work related causes?
		Do you have medical coverage through Medicaid?

If you answered YES to ANY of the above questions, please provide information below and a copy of your card.

Type of policy: _____

Insurance company name: _____

Claims Address: _____

Policy number: _____

Group number: _____

If coverage is through employment, please provide:

Employer name and address: _____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____