

HARRIS DERMATOLOGY

PATIENT INFORMATION

2018

Date Completed: _____

A. PATIENT INFORMATION

Name: _____

D.O.B.: _____ / _____ / _____ Last Age: _____ First Sex: M F SS#: _____ MI

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

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. Participating Plans (BC/BS and Aetna):** Patients are responsible for paying an estimated deductible, copayment, coinsurance and any non-covered and/or cosmetic service, at the time of service. Once the insurance company 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 Harris Dermatology 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 Harris Dermatology 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 Harris Dermatology; 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

Board Certified Dermatologists

Brian A. Harris, M.D. · Keith A. Harris, M.D. · H. Ross Harris, M.D.

Financial Policy

Harris Dermatology is not a participating member of your insurance plan. Because the physician is not on your plan, the expenses for your visit(s) are your responsibility and you are expected to pay the charges, in full, at the time of service.

After you have paid for your visit(s), Harris Dermatology will provide you with a properly coded insurance form. You may forward this form to your insurance company for reimbursement (we recommend you keep a copy for your files). Depending on your insurance benefits, you may be reimbursed only a percentage of the money you paid.

I agree to make full payment at the time of my appointment for services provided by Harris Dermatology.

Patient/Responsible Party's Signature

Date

Chart # _____

Locations:

9090 Park Royal Dr.
Fort Myers, FL 33908
Phone 239.936.3344
Fax 239.936.5126

5415 Park Central Court
Naples, FL 34109
Phone 239.596.1848
Fax 239.596.8084

HARRIS DERMATOLOGY

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: _____

HARRIS DERMATOLOGY

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

	YES	NO		YES	NO
LUNGS:			Other, Systemic:		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis (Past or present)	<input type="checkbox"/>	<input type="checkbox"/>
O ₂ Dependent/Use	<input type="checkbox"/>	<input type="checkbox"/>	Kidney _____	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR:			Thyroid _____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bladder _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stomach _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Bowel _____	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters/Herpes Simplex Virus	<input type="checkbox"/>	<input type="checkbox"/>
			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 _____
 Medical Assistant Initials

Signed by Physician _____ Date _____

Reviewed by _____ Date _____

HARRIS 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