

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

# 2018

Date Completed: \_\_\_\_\_

**A. PATIENT INFORMATION**

Name: \_\_\_\_\_

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

Marital Status:  Married     Single     Widowed     Divorced

Ethnicity:  Hispanic or Latino     Not Hispanic or Latino     Decline

Race:  White     Black or African American     Asian     Native Hawaiian or other Pacific Islander  
 American Indian or Alaska Native     Other \_\_\_\_\_     Decline

Preferred Language:  English     Spanish     Creole     Other \_\_\_\_\_

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



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: \_\_\_\_\_

**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

	YES	NO		YES	NO
<b>LUNGS:</b>			<b>Other, Systemic:</b>		
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 <sub>2</sub> Dependent/Use	<input type="checkbox"/>	<input type="checkbox"/>	Kidney _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>VASCULAR:</b>			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

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