MT. PLEASANT
DERMATOLOGY

PATIENT INFORMATION FORM (Please print)

Full Legal Name _____
(Last) (First) (MI)

Nickname _____Social Security Number _____

Date of Birth _____ Male _____ Female _____

Mailing Address _____

City _____ State _____ Zip Code _____

Alt Address *(if applicable)*

_____

Primary Phone _____ Secondary Phone _____

Email _____

Occupation _____ Employer _____

If Student Name of School _____

Preferred Language _____

Race □ White □ African American □ Alaska Native or American Indian □ Asian
□ Native Hawaiian or Pacific Islander □ Other _____ □ Decline to Specify

Ethnic Group □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Specify

Guarantor Responsible Party)

Name _____

Date of Birth _____ Relationship to Patient _____

Address *(if different from above)* _____

Home Phone (____)_____ Work Phone (_____)_____ Male ____ Female _____

Employer _____ Address _____

Primary Care Physician _____

Address _____ Phone (____) _____

Referring Physician _____

Address _____ Phone (____) _____

Preferred Pharmacy _____Phone (____)_____

Emergency Contact Name _____

Relationship _____ Phone _____

*** PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST SO COPIES CAN BE MADE***

Insurance Information

Medical Insurance: If your insurance policy requires a copayment, percentage, or deductible, this amount is payable at the time services are rendered. If our office is not a participating provider for your insurance or if a required referral has not been obtained, then payment is expected in full at the time of service.
This information below is in regards to the person whose name appears on the insurance card.

PRIMARY Insurance _____

ID # _____Group # _____

Insurance Address _____

Name of Insured _____

Insured's SSN _____ Insured's Date of Birth _____

Employer Name _____

SECONDARY Insurance _____

ID # _____Group # _____

Insurance Address _____

Name of Insured _____

Insured's SSN _____ Insured's Date of Birth _____

Employer Name _____

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Authorization, Assignment of Benefits, and Referral Medical Releases

I consent and authorize a Mt. Pleasant Dermatology physician and whomever they may designate as their assistant to provide me medical treatment and to use and disclose my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Mt. Pleasant Dermatology Notice of Information Practices.

I authorize the release of medical information, including complete medical records, test results, and billing information to my insurance company, to the other medical professionals, and/or medical care institutions that I may be referred to for treatment and for payment purposes.

I authorize payment directly to Mt. Pleasant Dermatology for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurances, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have provided on this form is accurate and true. I recognize it is my or my legal guardian's responsibility to keep this practice and my physician informed of changes to any of my contact information. A failure to do so may impact my ability to receive proper care for a medical condition.

Patient Legal Signature _____ Date_____

Legal Guardian Name (Print) _____ Relationship _____

Guardian Signature _____ Date _____

MT. PLEASANT DERMATOLOGY

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SKIN & MEDICAL HISTORY FORM

PATIENT NAME:_____**DOB:**_____

Occupation:_____**Hobbies:**_____

REASON FOR TODAY'S VISIT:_____**Date:** _____

List All Medications: (including over the counter medications) **NONE**

_____

_____

_____

List All Medication Allergies: **NONE**

_____

Have you had your flu shot this year? NO YES **Have you had your pneumonia shot?** NO YES

Smoking History: Never smoked Quit: former smoker Smokes less than daily Smokes daily

Alcohol Use: None Less than 1 a day (Socially) 1-2 Drinks daily 3 or more drinks daily

Skin Disease History: (Circle all that apply)

Acne Actinic Keratoses (AK's) Blistering Sunburns (even as a child) Dry Skin

Eczema Flaking or Itchy Scalp Hay Fever/Allergies Poison Ivy

Precancerous Moles Psoriasis Other: _____ **Basal Cell Carcinoma**

Squamous Cell Carcinoma **Melanoma**

Do you wear sunscreen? NO YES SPF Strength? _____ Does it contain Zinc Oxide? _____

How often do you wear sunscreen? Daily _____ Only During Outdoor Activities_____

Do you currently or have you ever tanned in a tanning salon? NO YES How long ago_____

Do you have a family history of Melanoma? NO YES Which relative(s)? _____

Do you have a family history of other skin cancers? NO YES Which relative(s)? _____ Do or did your parents have any chronic illnesses? _____ Which relative?_____

Cosmetics:

Are you interested in discussing cosmetic products and/or procedures? NO YES

What procedures are you interested in discussing? _____

What cosmetic procedures/surgeries have you had done? _____

What products are you currently using? _____

Past Medical History: NONE (Circle all that apply)

Anxiety Arthritis Asthma Atrial fibrillation
Benign Enlarged Prostate (BPH) Bone Marrow Transplantation Breast Cancer Colon Cancer
Chronic Obstructive Pulmonary Disease (COPD) Chronic Renal Failure or Kidney Disease
Coronary Artery Disease Depression Diabetes Hearing Loss
Gastroesophageal Acid Reflux Hepatitis High Blood Pressure HIV/AIDS
High Cholesterol Hyperthyroidism Hypothyroidism Leukemia
Lung Cancer Lymphoma Prostate Cancer Radiation Treatment Seizures
Stroke Other_____

Past Surgical History: NONE (Circle all that apply)

Coronary Artery Bypass or Stents Organ Transplant Basal Cell Cancer Surgery
Mechanical Valve Replacement Spleen Removal Squamous Cell Carcinoma Surgery
Biological Valve Replacement Melanoma Surgery
Knee Replacement Right Left Both How long ago? _____
Hip Replacement Right Left Both How long ago? _____

DO YOU HAVE ANY OF THE FOLLOWING: Please answer each question		
Have an allergy to lidocaine or epinepherine	NO	YES
Have an allergy to latex	NO	YES
Have an allergy to adhesive	NO	YES
Have an allergy to topical antibiotic ointments	NO	YES
Have pacemaker, defibrillator, or neurostimulator	NO	YES
Have an allergy to Vicryl or Monocryl Sutures	NO	YES
Currently taking daily aspirin, blood thinners, or anti-inflammatories	NO	YES
Had a joint replacement in the past two years	NO	YES
Have an artificial heart valve	NO	YES
Require antibiotics prior to having a dental procedure	NO	YES
Have a history of Hepatitis B or C	NO	YES
Have a history of HIV/AIDS	NO	YES
Have a history of fever blisters or HSV	NO	YES
Have active Tb	NO	YES
Have stomach upset while taking antibiotics	NO	YES
Any recent travel to West Africa or contact with someone who has	NO	YES
(Females only) Are pregnant or planning a pregnancy	NO	YES
(Females only) Are a nursing mother	NO	YES

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PERMISSION FOR VERBAL & ELECTRONIC COMMUNICATION

Patient Name _____ Date of Birth _____

I am authorizing Mt. Pleasant Dermatology, their physicians, nurses, and other personnel to discuss my medical information, in person or by phone, with the following individuals listed below. I understand that if I choose not to list anyone on this form that my health information will not be shared with anyone other than myself. **This document does not authorize the release of any written health information.**

Unless indicated otherwise, this authorization includes disclosure of medical information to include office visits, lab/pathology findings, and treatment plans.

If at any time I wish to revoke any authorizations included on this form, I must contact the office, in writing and signed by me.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medical conditions you wish to exclude from verbal communications

_____

Permission for Communications (Please initial for approval)

_____ I authorize Mt. Pleasant Dermatology to leave a confidential voice mail message regarding upcoming appointments. **I understand that no test results will be left on voice mails.** Please list a number below where you wish to receive voice mails.

_____ Home Cell Work Other

_____ I authorize Mt. Pleasant Dermatology to use my patient portal to communicate with me regarding my health, medication refills, or other questions I may have.

_____ I authorize Mt. Pleasant Dermatology to use text/email for appointment reminders.

Prescription Medication Consent

The providers at Mt. Pleasant Dermatology use an electronic medical record system that allows electronic prescribing of medications. This system also has the ability to access any other medication history prescribed to you in the past from other providers. By signing below I indicate that Mt. Pleasant Dermatology may access my medication history.

THIS FORM DOES NOT EXPIRE UNLESS REVOKED OR UPDATED.

_____ _____

Signature of Patient or Responsible Party **Date**

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PATIENT FINANCIAL POLICY

Thank you for choosing Mt. Pleasant Dermatology for your skin care needs.

Mt. Pleasant Dermatology will gladly file your insurance claim for you. We do ask that you provide us with the necessary information to do this. We will need a copy of your insurance card to be sure we have the correct insurance billing information. If a billing problem arises, we may ask you to provide (verify) additional information concerning your coverage. It is the responsibility of the patient to notify Mt. Pleasant Dermatology of any changes in coverage.

For patients who are covered by insurance plans in which our physicians are not contracted providers, you will be required to pay 50% of the charges at the time of service. After we file the claim and receive payment, you will be billed for any unpaid charges, regardless of the benefits and payment policies of the plan.

For self-pay and patients having a service provided that is not covered by insurance, all charges will be collected at the time of service.

Please review the following policies:

- Payments are required at the time of service; including co-pays, coinsurance, deductibles and any other unpaid balances.
- It is the patients' responsibility to ensure that the proper referral is completed before visit/treatment. The visit may be rescheduled if the proper referral is not obtained.
- Be prepared to provide your insurance card at every visit (this helps us ensure we have the most accurate information).
- A parent or legal guardian must accompany minors for their appointments or have a release on file giving the physician permission so see the minor without a parent present. Depending on the visit, you may be asked to reschedule if an adult is not present.

Please review the following financial policies:

- Missed appointments not canceled/rescheduled within 24 hours
  $40
- Missed procedures/cosmetic/surgery appointments not canceled or rescheduled within 24 hours $100

****These charges are not covered by insurance and are the patient's responsibility****

Lab Tests & Biopsies

In order to properly take care of your medical needs many times we are required to send specimens to a dermatopathologist for diagnostic purposes**. It is the responsibility of the patient to notify the office if lab tests need to be sent to a specific lab.** Otherwise, you will be responsible for the charges incurred if the lab work is sent to an "out of network" lab.

Please be aware that you will receive a separate bill from the lab for any lab work that is obtained by our office and sent to them for testing. We will provide them with your insurance information.

_____ _____

Signature of Patient or Responsible Party **Date**