DATE

ADVANCED DERMATOLOGY & SKIN CARE CENTRE

Thomas Bender MD Ronald Johnston MD Alan Stanford MD Virginia Reeder MD William Henghold MD
James Wharton MD Cary Dunn MD Greg Sharp PA-C Jessica Davis PA-C Kellie Toth PA-C Erin Risco NP-C

CIRCLE ALL THAT APPLY NEW PATIENT ESTABLISHED/RETURNING PATIENT REFERRED WORK COMP

PATIENT INFORMATION - Circle Applicable Answers

Patient's FIRST Name, MI:			Patient's LAST Name:
Street Address: No PO Box			◯Home ◯Cell ◯Work Primary Phone #: ( )
City:	State:	Zip:	◯Home ◯Cell ◯Work Secondary Phone #: ( )
SS#:	Marital Status: M / S / D / W		E-mail:
Date of Birth:	Gender: M F		Preferred Pharmacy Advanced Care Pharmacy Other:
Employment Status: Full time Part time Retired Student N/A			Referred by:
Occupation:			Does your insurance require referrals? Yes / No
Company or School Name:			Did your physician refer you to us? Yes / No
Circle Race: African-American Asian Caucasian Hispanic Other			Referring Physician Full Name:
Ethnicity: Cuban Not Hispanic or Latino Other:			Primary Care Physician Full Name:
Language: English Spanish Other:			Physically Impaired: No Hearing Vision Other:
Are you currently receiving Hospice/Home Health Care? NO YES ☞			Hospice/Home Health Care Company Name

EMERGENCY CONTACT:

Name (First, Last):	Name (First, Last):
◯Home ◯Cell ◯Work Contact#: Relationship Self Spouse Child Other	◯Home ◯Cell ◯Work Contact #: Relationship Self Spouse Child Other

OTHER THAN PATIENT - PERSON RESPONSIBLE FOR ACCOUNT BALANCES – COMPLETE REQUIRED INFORMATION INCLUDING MAILING ADDRESS

FIRST Name, MI:			LAST Name:	
Street Address: No PO Box			◯Home ◯Cell ◯Work Primary Phone #: ( )	
City:	State:	Zip:	Date of Birth:	Gender: M F

IF OTHER THAN PATIENT - COMPLETE REQUIRED INFORMATION BELOW ONLY IF WE ARE TO FILE YOUR INSURANCE

PRIMARY INS. SUBSCRIBER/CARDHOLDER		Circle Relationship to Patient: Self Spouse Child Other	
Primary Ins. Name:			Co-pay Amt
Effective Date:	Group #:		Policy/ID #:
Subscriber's Name: REQUIRED TO FILE		Subscriber's DOB: REQUIRED TO FILE	Gender: M F

SECONDARY INSURANCE -- COMPLETE INFORMATION BELOW

SECONDARY INS. SUBSCRIBER/CARDHOLDER		Circle Relationship to Patient: Self Spouse Child Other	
Secondary Ins. Name:			Co-pay Amt
Effective Date:	Group #:		Policy/ID #:
Subscriber's Name: REQUIRED TO FILE		Subscriber's DOB: REQUIRED TO FILE	Gender: M F

edited 8/8/2017
edited 3/6/2017
developed 9/4/2014
Y:REGDOC:2017:17REGDOC

Messages / Voice	If I am unreachable, Advanced Dermatology physicians or staff ☐ may ☐ may NOT leave voice messages	
PERSONAL RELEASE OF INFORMATION PERSONAL RELEASE OF INFORMATION – You may elect to RESTRICT OR ALLOW Advanced Dermatology from discussing medical information including but not limited to appointments, treatments, diagnosis, prognosis, medications, with the following people listed. PLEASE INDICATE BELOW		
☐ RESTRICTED – DO NOT RELEASE INFORMATION	☐ ALLOW –RELEASE INFORMATION TO PERSON(S) BELOW	
YOU MUST LIST FULL NAMES OF EACH PERSON(S)		

PATIENT RESPONSIBILITY **It is your responsibility to** Our physicians participate in many insurance plans and managed health care programs Our office will submit a claim for services rendered for patients participating in those plans for which our physicians are providers. ●Provide our office with accurate and complete insurance information. You are responsible for payment of any resulting denied claims. ●Federal (Red Flag Rules) prevent us from filing to insurance without proof of identification. We will not bill your insurance carrier.●Present photo ID and insurance card(s) to every office visit. We will not bill your insurance carrier without valid photo ID. ●Pay all amount(s) due, including but not limited to balances, co-pay, coinsurance and/or deductible prior to each visit. Payment can be made by cash, check or credit card, or a payment plan may be arranged.

REFERRALS/AUTHORIZATIONS - I understand it is my responsibility to request & to notify Advanced Dermatology of any referrals or prior authorizations required by MY insurance company. If I do not have the correct authorization/referral my visit may be rescheduled or I will be responsible for payment for all costs of treatment.

CONSENT TO MEDICAL SERVICES – I authorize Advanced Dermatology to render treatment to me/my dependents for Dermatological care as may be deemed necessary. I understand any procedure including but not limited to laser treatments, cryotherapy, biopsy, chemical peel; may result in discoloration or scarring; this risk is significantly increased with sun exposure 4 weeks prior to treatment. I understand I am to notify & return to clinic if any lesion or rash does not improve and resolve within 2 weeks for further examination\treatment.

DIGITAL PHOTOGRAPHY – I authorize physicians and staff of Advanced Dermatology to take digital photographs that relate to my care. Advanced Dermatology will only disclose information relevant to MY treatment. Advanced Dermatology may use images that do not disclose identity in professional publications, teaching purposes, or textbooks unless stated otherwise.

PERSONAL PROPERTY - I understand & I agree to hold Advanced Dermatology & Skin Care Centre, physicians and staff harmless from any and all liability and relieve Advanced Dermatology & Skin Care Centre, et al from any and all responsibility for loss or damage of any personal property, valuables, money or any other personal belongings located in or on the premises.

MISSED APPOINTMENTS – Our office requires 24-hour notice for cancellations/appointment/procedure rescheduling. Failure to do so may result in a $30 fee for medical appointments and a $50 fee for cosmetic appointments.

ADVANCED CARE PHARMACY – FINANCIAL DISCLOSURE TO PATIENTS – This notice informs you that Gulf Coast Dermatology & Skin Care Centre, PLLC D/B/A Advanced Dermatology & Skin Care Centre has ownership interest in Advanced Care Pharmacy. Physicians who have ownership interest in Advanced Dermatology & Skin Care Centre may indirectly receive compensation for prescriptions you have filled at this entity or other items or products you purchase. You have a choice in pharmacies and are not obligated to use this pharmacy.

PRIVACY POLICY NOTICE – I understand I may request a copy of Advanced Dermatology's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted by federal law

E-RX I understand as part of my electronic health record; Advanced Dermatology will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my primary pharmacy provider.

SURESCRIPTS PRESCRIPTION NETWORK DATABASE- I authorize Advanced Dermatology & Skin Care Centre to access my Surescripts Medication History in order to make more informed clinical decisions regarding my healthcare. I understand this information will become part of my electronic healh record. Surescripts Policy is available upon request.

STATEMENT TO PERMIT PAYMENT OF BENEFITS TO PROVIDER– I hereby assign and authorize payment of my insurance benefits, including authorized Medicare benefits, sick benefits, injury benefits due because of liability of a third party, or proceeds of all claims resulting from liability of third party, payable by any party, organization directly to Advanced Dermatology & Skin Care Centre to release any medical or other information for the purpose of processing claims to my insurance carriers, including Heath Care Financing Administration and future insurance changes. This includes information as defined by and for the purposes outlined in the Privacy Notice. I have read and understand all of the above. I understand that in the event I do not pay for services rendered and amounts become delinquent, I am obligated for all costs including collection, court and attorney fees.

I permit a copy of this authorization to be used in the place of the original.

Advanced Dermatology aims to provide exemplary patient care during each and every interaction. Your satisfaction is our primary concern. If you have any issues or concerns notify us by calling Ashley Kirk O'Rourke (251) 631-3570 ext. 114 or by email info@AdvancedDermClinic.com. Thank you for entrusting Advanced Dermatology with all of your skin care needs.

Signature of Patient or Authorized Representative Date

Witness Signature Date

ADVANCED DERMATOLOGY & SKIN CARE CENTRE MEDICAL HISTORY Today's Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____

Are you allergic to Medications: YES NO If "YES": list below

1. _____ 2. _____ 3. _____

Have you ever had dental anesthesia (Novocain)? YES NO Any bad reactions: YES NO If "YES," what? _____

Please list medications you are currently taking. (Including prescription, over the counter, and vitamins)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you have now, or ever had any of the following diseases or conditions: (Please check YES or NO)

MEDICAL HISTORY - PATIENT	YES	NO
Prescribed Blood thinners		
Bronchitis		
Emphysema		
Asthma		
Chronic cough		
High blood pressure		
Heart attack		
Irregular heart beat		
Blood clots		
Pacemaker		
Defibrillator		
Diabetes		
Thyroid Disease		
Kidney disease / Dialysis		
Bladder problems		
Hepatitis / infectious disease		
Arthritis / Joint deformity		
Artificial joint		
Convulsions / Seizures / Epilepsy		
Lupus or Autoimmune disorder		
Dementia		
Skin Cancer		
Specific Skin Disease		
Any diseases or conditions not listed?		

FAMILY HISTORY	YES	NO	Person Diagnosed
Autoimmune disorder			
Diabetes			
Heart Disease			
High Blood Pressure			
Melanoma			
Skin cancer Non Melanoma			
Psoriasis			
Any other skin disease			

SOCIAL HISTORY - PATIENT	YES	NO
Do you use tobacco?		
If yes, How much:		
If quit, then when:		
Do you drink alcohol?		
If yes, how often:		
Any IV / Illegal drug usage?		
Exposure to HIV (AIDS)?		
Sexually Transmitted Disease		
Women: Are you pregnant or breast feeding?		
-- If pregnant, enter due date:		

SKIN HISTORY	YES	NO
Any surgery in the past 6 months?		
Do you have problems healing?		
Do you develop keloids (thick scars)?		
Do you bleed easily?		
Ever had a rash in reaction to :		
Medication		
Food		
Environment		
Bandages		
Topical Neosporin		
Other		

Form Completed by (circle one):
Patient Family member/Guardian Medical Assistant

TODAY'S/RECENT ISSUES - REVIEW OF SYSTEMS	YES	NO
Allergies/Immunologic (e.g., seasonal allergies, itchy eyes, runny nose)		
Cardiovascular (e.g., chest pain, palpitations)		
Constitutional/Symptoms (e.g., fever, nausea)		
Endocrine (e.g., low energy, cold intolerance)		
Ears, nose, throat, mouth (e.g., swallowing problems, cold sores)		
Urinary (e.g., blood in urine, pain with urination)		
Bowel (e.g., diarrhea, unplanned weight loss)		
Blood/Lymphatic (e.g., enlarged nodes or glands)		
Muscle/ Joint (e.g., muscle aches, arthritis)		
Psychiatric (e.g., depression, anxiety)		
Respiratory (e.g., difficulty breathing, wheezing)		
Skin Condition (e.g., rash, non-healing sore)		
Receiving Hospice Care		

Signature: _____ Date: _____