

Patient Information Form

Name: _____ First MI Last Nickname: _____

Mailing Address: _____ City/State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Birth Sex: _____ SSN#: _____

Email Address: _____ *By providing your email, you agree to receive communication including a company newsletter. If you wish to opt-out of this indicate here. No, thanks*

Phone Number (home): _____ Phone Number (cell): _____

Phone Number (work): _____ Employer: _____

Preferred Contact: Phone / Text / Email Preferred Language: _____

Race (circle one): White / Black/African / American Indian / Asian / Native American / Hispanic / Other

Ethnic Group (circle one): Hispanic or Latino / Not Hispanic or Latino Preferred Pronoun: He / She / They

Gender Identity: Male / Female / Transgender Male / Transgender Female / Genderqueer / Other: _____

Marital Status (circle one): Minor / Single / Married / Widowed / Divorced / Separated

Insured Party Name: _____ Insured Party Employer and Phone: _____

Responsible Party (Guarantor) Name: _____ Guarantor DOB: _____

Guarantor Street Address: _____ City/State: _____ Zip Code: _____

Guarantor Primary Phone: _____ Guarantor Work Phone: _____

IF THE PATIENT IS A MINOR OR DEPENDENT, COMPLETE THIS SECTION:

Primary Parent's Name: _____ First MI Last DOB: _____

Street Address: _____ City/State: _____ Zip Code: _____

SSN#: _____ Employer: _____ Primary Phone: _____

Patient lives with (circle one): Both parents / Mother / Father Other: _____

If the legal guardian is unable to accompany the minor patient to their appointment, who else may accompany the patient to their appointment? _____

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

If I choose not to accompany my minor child or dependent to his/her follow-up appointments, I authorize the primary provider to perform treatments and/or procedures necessary to deliver appropriate healthcare. I understand this will include evaluation and management for the presenting problem. I understand it may also include prescription of medication, administration of local anesthesia, application of liquid nitrogen, as well as other minor procedures.

I will accompany my minor child or dependent to his/her follow-up appointments. I understand if I do not accompany him/her, he/she will not be seen.

Parent or Guardian Signature: _____ Date: _____

Emergency Contact

Nearest Friend or Relative NOT living with you: _____ Relationship: _____

Primary Phone: _____ Alternate Phone: _____

Advanced Practice Providers (APPs): This office employs Nurse Practitioners and Physician Assistants. Occasionally and/or routinely your visit will encompass evaluation/treatment by our Advanced Practice Providers as either a component of your visit, or, if necessary, in place of the physician on staff. Our APP's work closely with and are supervised by our physician in all aspects of your care.

PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE

TO BE COMPLETED FOR ALL MEDICARE PATIENTS ONLY

1. Are you a veteran? **YES NO**
 - a. Did the VA refer you here for treatment? **YES NO**
 - b. Do you have a VA "fee basis" ID card? **YES NO**
2. Do you have a Federal Black Lung Card? **YES NO**
3. Is this medical condition due to an accident of any kind? **YES NO**
If yes, was it: __ Work related; __ Auto; __ Injured in own home; Other: _____
4. Are you covered by an employer's health insurance through your own employment or that of a family member? **YES NO**
If yes, does that employer have more than 20 employees? **YES NO**
5. Have you recently joined a Medicare Advantage Plan? **YES NO**
If yes, identify: _____
6. Are you covered by a commercial HMO/PPO, which makes Medicare secondary insurance? **YES NO**

It is the policy of this office to review the accuracy of this information annually.

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Heartland Dermatology Center, PA for any services furnished to me by their providers. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature: _____ **Date:** _____

MEDIGAP PAYMENT AUTHORIZATION (Secondary Insurance)

I hereby authorize payment of my Medigap benefits from _____ to Heartland Dermatology Center, PA for all claims on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient Signature: _____ **Date:** _____

INSURANCE AUTHORIZATION AND PAYMENT POLICY

Primary Insurance: _____	Secondary Insurance: _____
Policy Holder: _____	Policy Holder: _____
Policy Holder SSN#: _____	Policy Holder SSN#: _____
Policy Holder DOB: _____	Policy Holder DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____

1. I understand Heartland Dermatology Center is a participating provier with BC/BS, Medicare, PHC, Coventry, WPPA, UHC Kancare, United Healthcare, HPK Network, and TriCare. I am responsible for any amounts not covered by any insurance or other party.
2. I understand that all co-pays are due at time of service.
3. I understand I may request a payment plan prior to seeing the provider.
4. I request that payment of benefits be made on my behalf to Heartland Dermatology Center for any services furnished by their providers.
5. I hereby authorize Heartland Dermatology Center to furnish information to insurance carriers concerning my illness and treatments.
6. I understand and verify all information is correct to the best of my knowledge.
7. **TRICARE PATIENTS:** If a referral is required, it is your responsibility to ensure our office receives this prior to your appointment.
8. **ALL OTHER INSURANCES:** If our office is not assigned or contracting with your insurance company, you will be required to pay for all services rendered to you. It is your responsibility to check with your insurance company regarding our contract prior to your appointment.

Patient signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

1. I acknowledge that I have had an opportunity to review and or/received Heartland Dermatology Center's "Notice of Privacy Practices."
2. I consent to Heartland Dermatology Center's use and disclosure of my personal health information to carry out treatment, payment and healthcare options unless I have determined to pay for services in full at time of service.
3. I understand this means Heartland Dermatology Center may call and leave a message on voicemail or in person in reference to any items that assist in meeting my healthcare needs, such as appointment reminders, insurance items, laboratory results, clinical care information among others. I also understand Heartland Dermatology Center may also mail items to my home or other designated location such as appointment reminders, statements, brochures, and other items.
4. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I understand if I do not sign this consent, Heartland Dermatology Center may decline to provide treatment to me.

5. **I WISH TO ALLOW THE FOLLOWING PERSON(S) TO ACCESS ANY INFORMATION CONCERNING MY HEALTHCARE:**
_____ **Patient must initial:** _____

Patient signature: _____ **Date:** _____



Intake and History Form

Patient Name: _____ Height: _____ Weight: _____

Date of Birth: _____ Age: _____ Gender: _____ Preferred Language: _____

Place of Birth (City, State and Zip): _____

Employer: _____ Occupation: _____

Primary Doctor: _____ Referring Doctor: _____

Preferred Pharmacy

Name: _____ Phone Number: _____ City: _____

What is the main concern for your visit today? _____

What areas of your body are affected? _____

How long have you had this concern? _____

Symptoms (circle all that apply): pain itch bleeding enlargement spreading burning redness
embarrassment blistering other: _____

What oral medications have you tried for this concern? _____

What topical medications (prescription or OTC) have you tried? _____

List any other treatments you have used: _____

Which of these products have been helpful? _____

Past Medical History

Select any of the following medical conditions that you currently have or have had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Esophageal Reflux (GERD) | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Transplant of Bone Marrow |
| <input type="checkbox"/> Benign Prostatic Hyperplasia (BPH) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cerebrovascular Accident (CVA) | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Transplant (Organ): _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis (Type): _____ | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | _____ |
| <input type="checkbox"/> Disease caused by COVID-19 | <input type="checkbox"/> Lymphoma | _____ |
| <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Lung Cancer | _____ |
| | <input type="checkbox"/> Breast Cancer | _____ |

Past Surgical History

Select any of the following surgical procedures that you have had:

- | | |
|---|---|
| <input type="checkbox"/> Rectum: Abdominoperineal resection (APR) | <input type="checkbox"/> Ovaries (Oophorectomy) |
| <input type="checkbox"/> Joint replacement: Knee (Right / Left / Both) | <input type="checkbox"/> Pancreas: Pancreatectomy |
| <input type="checkbox"/> Breast: Biopsy of Breast | <input type="checkbox"/> Kidney: Kidney Stone Removal |
| <input type="checkbox"/> Prostate: Biopsy of Prostate | <input type="checkbox"/> Liver: Portosystemic Shunt Operation |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Graft (CABG) | <input type="checkbox"/> Prostate: Prostatectomy |
| <input type="checkbox"/> Kidney: Kidney Transplant | <input type="checkbox"/> Joint Replacement: Hip (Right / Left / Both) |
| <input type="checkbox"/> Ovaries: Tubal ligation | <input type="checkbox"/> Spleen: Splenectomy |
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Kidney: Nephrectomy |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Testicle: Orchidectomy |
| <input type="checkbox"/> Colon (Colectomy) | <input type="checkbox"/> Heart Transplant |
| <input type="checkbox"/> Liver (Hepatectomy) | <input type="checkbox"/> Liver Transplant |
| <input type="checkbox"/> Heart: Percutaneous Transluminal Coronary Angioplasty (PTCA) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart: Tissue Graft Heart Valve Replacement | _____ |
| <input type="checkbox"/> Bladder (Cystectomy) | _____ |
| <input type="checkbox"/> Prostate: Transurethral Prostatectomy (TURP) | _____ |
| <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Kidney Biopsy | _____ |
| <input type="checkbox"/> Rectum: Lower Anterior Resection | _____ |
| <input type="checkbox"/> Breast: Lumpectomy (Right / Left / Both) | _____ |
| <input type="checkbox"/> Breast: Mastectomy (Right / Left / Both) | _____ |
| <input type="checkbox"/> Heart: Mechanical Heart Valve Replacement | _____ |

Skin Disease History

Have you had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Blistering Sunburns |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Dry Skin (Asteatosis Cutis) | <input type="checkbox"/> Hay Fever / Allergies | _____ |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Malignant Melanoma | _____ |
| <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Flaking or Itchy Scalp | _____ |
| <input type="checkbox"/> Precancerous (Dysplastic) Moles | <input type="checkbox"/> Psoriasis | _____ |
| | <input type="checkbox"/> Squamous Cell Skin Cancer | _____ |

Do you wear sunscreen? YES NO If yes, what SPF? _____

Do you tan in a tanning salon? YES NO

Do you have a family history of malignant melanoma? YES NO If yes, which relative? _____

Do you have a family history of Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC)? YES NO
If yes, which relative? _____

Patient Name: _____

Medications

List all current medications (prescription, OTC medications and supplements) including dose and frequency:

Medication Name	Dose	Frequency

Allergies

List all allergies to medications

Social History

Smoking Status (Choose one)

- Current everyday smoker
- Current occasional smoker
- Cigar smoker
- Former smoker
- Never smoker

Alcohol Intake (Choose one)

- None
- Less than 1 drink per day
- 1 to 2 drinks per day
- 3 or more drinks per day

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Immunizations

For patients 65 and older, have you received the Pneumococcal (Pneumovax) vaccine? YES NO

For patients 50 and older, have you received the Shingles (Zostavax) vaccine? YES NO

For all patients, have you received the Influenza vaccine this flu season? YES NO

Review of Systems

Are you currently or have you recently experienced any of the following (mark all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Cough | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain/burning on urination |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> New onset of joint aches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Numbness/weakness |

Alerts

Select any of the following that you have (mark all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to Topical Antibiotic Ointment | <input type="checkbox"/> Premedication Prior to Procedures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Rapid Heartbeat with Epinephrine |
| <input type="checkbox"/> Artificial Joint within the past 2 years | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Planning Pregnancy |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Breastfeeding |

Patient or Patient Representative Signature

Date

Health Care Provider Signature

Date