

patient information

| first name: | last name: | | | | | | |
|---|----------------|--------------------------|-------------|-----|--|--|--|
| address: | | | | | | | |
| street address | city | state | zip | | | | |
| email: | | _ date of birth: | _ gender: M | l F | | | |
| cell telephone: | | _ land line home number: | | | | | |
| let us know if you were ref | erred by a fri | end! if so, who? | | | | | |
| past medical history: | | | | | | | |
| past surgical history: | | | | | | | |
| skin cancer history (please | note type ar | nd location): | | | | | |
| medications: please list all | current med | ications | | | | | |
| medication allergies: | | | | | | | |
| are you allergic to latex or adhesives? | | | yes | no | | | |
| are you pregnant, currently trying to get pregnant, or nursing? | | | yes | no | | | |
| family history of melanoma (if yes, which relative): | | | | | | | |
| preferred pharmacy: | | | | | | | |
| | name | city/state | zip code | ; | | | |



certification of active and valid insurance and assignment of benefits

| patient name: | | | | |
|---|---|--|---|--|
| last | | first | | |
| primary insurance carrier: | | ID number: | | |
| subscriber/name of insured: | | SU | bscriber DOB: | |
| relationship to subscriber: self | spouse | parent | child | |
| secondary insurance carrier (if you have o | one): | | | |
| subscriber/name of insured: | relationship to subscriber: | | | |
| | subscriber DOB: | | | |
| I hereby authorize Skinfocused Dermat process this claim and also authorize performed the process this claim and also authorize permatology LLC. I voluntarily declare that I have valid an and am responsible for payment if my participates with. I fully understand that I will be responsible determines that the services I receive a I also understand that I am responsible indicated by my health plan and agree service charges over and above this in A photocopy of this assignment shall be authorize the release of any information attorney involved in this case. Please keep in mind – if you are here for documented – we will be required to sepayment as well as additional finance. | payments directly ation and treatment directly ation and treatment directly active health in health plan is not all the for payment directly are at this facility are at this facility are at the for all deductiby to pay in a currectly surance payment be considered as an pertinent to my or a cosmetic secubmit a claim to | y to Skinfocused ent by the physical surance as detailed to the services of the services he time of service, in their opinion le, co-payment, ent manner, any out. It is effective and very case to any instruction of the service and a median or the service and a servic | d Dermatology. icians of Skinfocused ailed above for the doctor visit ocused Dermatology rendered by Skinfocused ce and/or if my health plan and the medically necessary. and co-insurance amounts as a balance of said professional alid as the original. I also surance company, adjuster, or dical opinion is sought and which may result in a | |
| signature (and relationship, if other th | nan patient) | | date | |
| privacy notice | written ackn | owledgement | İ | |
| All healthcare providers are now required to healthcare information. The Health Insurance requires our practice to make these regulation an opportunity to review our privacy notice. how your information is used and disclosed. Dermatology has the right to change this not | e Portability and ons accessible t Please feel free In addition, you ice at any time. | Accountability o our patients, to request a cu | Act of 1996 (HIPAA) and please know you have urrent copy that describes nowledges that Skinfocused | |
| signature (and relationship, if other | er than patient) | | date | |