North Suburban Dermatology Associates

How did you find us?

❑ Family/Friend - Name: _____
❑ Insurance Provider List
❑ Internet Search
❑ Newspaper Ad
❑ Physician - Name: _____
❑ Yellow Pages
❑ Other _____

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Preferred Name: _____
("John", "Mr. Jones", etc.)

Mailing Address: _____
(If PO Box, complete Street Address below)

City: _____ State: _____ Zip: _____

Street Address: _____
(complete only if Mailing Address provided above is a PO Box)

City: _____ State: _____ Zip: _____

PCP/Family Dr: _____ Phone: (_____) _____

Patient Date of Birth: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Patient Social Security Number: _____ – _____ – _____

Email: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (_____) _____ Occupation: _____

Preferred Phone: (_____) _____ ➡ ❑ Cell ❑ Home ❑ Work ❑ Other: _____
May we leave a confidential voice mail on this phone? ❑ Yes ❑ No

Alternate Phone: (_____) _____ ➡ ❑ Cell ❑ Home ❑ Work ❑ Other: _____

May we leave a confidential voice mail on this phone? ❑ Yes ❑ No

May we text you on your cell? ❑ Yes ❑ No

INSURANCE INFORMATION ❑ Self Pay Co-Pay Amount $ _____

Primary
Insurance: _____ ID#: _____

Policy Holder: Group# _____
❑ Patient (if not patient, complete information below)
❑ Name: _____ DOB: _____

SS# _____ Relation _____

Address: _____
(if different from patient's)

City: _____ State: _____ Zip: _____

Secondary
Insurance: _____ ID#: _____

Policy Holder: Group# _____
❑ Patient (if not patient, complete information below)
❑ Name: _____ DOB: _____

SS# _____ Relation _____

Address: _____
(if different from patient's)

City: _____ State: _____ Zip: _____

Does your insurance plan require you to have a referral to see a specialist? ❑ No ❑ Yes ❑ I don't know
NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

IMPORTANT– WE ARE NOT CONTRACTED WITH ANY WORKERS COMP OR MEDICAID PLANS.

CMS QUALITY REPORTING INFORMATION: My preferred language is: ❑ English ❑ Spanish ❑ Other
Race (optional): ❑ White ❑ Black/African American ❑ Asian ❑ Hispanic ❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ Other

PHARMACY INFORMATION (WHERE YOU MOST OFTEN GET PRESCRIPTIONS FILLED):

Pharmacy 1: _____ Location: _____ Phone: (_____) _____

Pharmacy 2: _____ Location: _____ Phone: (_____) _____

Mail Order: _____ Location: _____ Phone: (_____) _____

CONTACT IN CASE OF EMERGENCY: ❑ Check only if this person is **NOT** to be included in MEDICAL RELEASE section below.

Name: _____ Phone #(s): _____ Relationship: _____

MEDICAL RELEASE: Please list any persons to whom your protected health information can be disclosed (e.g. spouse, parent, etc):

Name: _____ Phone #(s): _____ Relationship: _____

Name: _____ Phone #(s): _____ Relationship: _____

Signature (Patient or Guardian) _____ **Date** _____

North Suburban Dermatology Associates

For Office Use:
Date of Appointment: ____/____/____
Time of Appointment: _____ am / pm
Initials: _____
Account #: _____

MEDICAL HISTORY

Patient _____

List any medications, herbal supplements and/or vitamins you are currently taking: [❑ Not taking any medications]

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have or have you had any of the following? *(if yes, please check)* ❑ None

- ❑ Acne
- ❑ Artificial heart valve
- ❑ Artificial joints or metal implant
- ❑ Atopic Dermatitis
- ❑ Atypical moles
- ❑ Autoimmune disease (lupus, rheumatoid arthritis)
- ❑ Bleeding disorder
- ❑ Blood clots
- ❑ Cold sores/herpes
- ❑ Depression
- ❑ Diabetes
- ❑ Heartburn/Reflux
- ❑ HIV
- ❑ High blood pressure/Hypertension
- ❑ Keloids or scarring problems
- ❑ Kidney disease
- ❑ Liver disease or hepatitis
- ❑ Lung disease
- ❑ Psoriasis
- ❑ Seasonal allergies/asthma
- ❑ Skin Cancer
- ❑ Skin Pre-Cancers (actinic keratoses)
- ❑ Thyroid trouble
- ❑ Ulcers (stomach)
- ❑ Other conditions
  Please List: _____

Female patients (check all that apply): I am ❑ pregnant ❑ nursing ❑ planning to become pregnant in the near future

Are you allergic to any medications/anesthetics? ❑ Yes ❑ No
(if yes, please list)

_____ _____ _____

Please list major surgeries/hospitalizations:

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

Please list IMMEDIATE FAMILY that have had any of the following (mother, father, maternal or paternal grandmother or grandfather, brother, sister):

❑ Skin Cancer-Melanoma: _____ ❑ Psoriasis: _____

❑ Skin Cancer-Other: _____ ❑ Eczema: _____

❑ Other Cancers: _____ ❑ Other: _____

Smoking Status:
❑ Never ❑ Former ❑ Current Daily ❑ Current Occasional

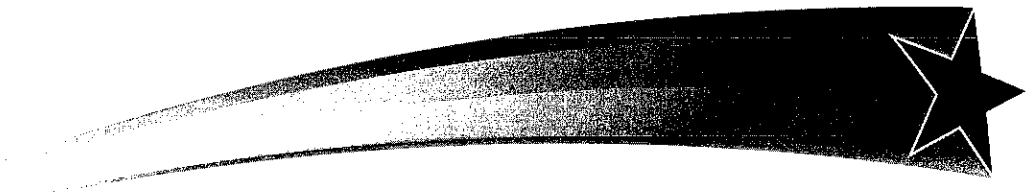
Do you use smokeless tobacco? ❑ Yes ❑ No
Drink alcoholic beverages? ❑ Yes ❑ No
Do you use recreational drugs? ❑ Yes ❑ No

Do you use sunscreen on a daily basis? ❑ Yes ❑ No
Have you traveled outside the U.S. in past 3 months? ❑ Yes ❑ No
Have you had at least one blistering sunburn? ❑ Yes ❑ No
Have you ever used a tanning bed? ❑ Yes ❑ No
Do you currently use a tanning bed? ❑ Yes ❑ No

Have you RECENTLY had any of the following? *(Please check all that apply)* ❑ None

- ❑ Other skin complaints
- ❑ Other systemic complaints
- ❑ Fever/chills/wt. change
- ❑ Sun sensitivity
- ❑ Itching
- ❑ Muscle Aches
- ❑ Joint Aches
- ❑ Ringing in ears

Thank you for taking the time to help us give you the highest quality care.



Patients MUST sign and date below before medical care can be rendered.

PATIENTS WHO ARE MINORS: Parents or legal guardians must sign for patients who are younger than eighteen. A parent or legal guardian must be present at all visits for any patient younger than eighteen.

Privacy Practices (HIPAA)

We use the contact information that you provide for appointment reminders and to contact you regarding your appointments and care. By signing below, I acknowledge that I have read and understand North Suburban Dermatology Associates' Notice of Privacy practices, which is available at the check-in desk.

Release of Medical Information

By signing below, I authorize the release of medical information to my primary care and/or referring physician, to medical consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Financial Policy

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. We accept payment in the form of cash, check, and most credit cards. In the event that your account must be turned over to collections or becomes delinquent, a $25.00 fee will be added to your account. Accounts that are delinquent after 45 days of being sent to collections may accrue additional collection agency fees and legal fees. For appointments which are missed or canceled with less than 24 hours notification, there may be a $25.00 - $75.00 missed appointment fee added to your account depending on the appointment type. Please understand that missed appointments with little or no notice prevent other patients who are on a waiting list from being seen by the doctor. A $25.00 fee is assessed for all returned checks. Your signature below signifies your understanding and willingness to comply with this policy.

_____ Initial

I have read and understand the financial policy statement. I agree to make in-full prompt payment to North Suburban Dermatology Associates when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to North Suburban Dermatology Associates for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Name: _____

Patient Signature: _____ Date: _____/_____/_____

Guardian Name (if patient is younger than 18): _____

Guardian Signature: _____ Date: _____/_____/_____

North Suburban Dermatology Associates

Patient Account #_____

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance(s) have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays are due at the time of the visit will, of course, still be due at time of service.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,

North Suburban Dermatology Associates

I authorize North Suburban Dermatology Associates to charge outstanding balances on my account to the following credit card:

Card Type: ❑ Visa ❑ Mastercard ❑ Discover ❑ American Express ❑ Care Credit

Category: ❑ Debit ❑ Credit ❑ Healthcare Credit/Debit Card (HSA, FSA, flex spend, etc.)

Account Number:_____ Security Code:_____ Exp Date _____

Name on Card (please print):_____

Signature:_____ Date:_____

POS Reorder # 1901647

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