



Welcome to North Suburban Dermatology Associates!

Attached is our Patient Registration Package. Please complete these so we can maintain accurate contact and medical records. Please bring the completed original forms with you to your appointment along with the other items listed at the bottom of this letter.

We realize that you have a choice of where to be treated. We also realize that you place a great deal of trust in your health care providers to provide you with the most up-to-date information and treatment options regarding your skin care. We do appreciate and value the trust you have placed in us.

North Suburban Dermatology Associates specializes in the diagnosis and treatment of skin, hair and nail disease. We provide our patients and their families with comprehensive dermatologic treatment. We want to help you get the best of what today's medicine has to offer. We are committed to high-quality, cost effective patient care with an emphasis on individual attention for each patient. Providing the best service possible, in a comfortable, private atmosphere is extremely important to us. We will do our utmost to give you total satisfaction.

We place a high value on our relationship with our patients. We especially value patient feedback. Be assured that comments matter; it helps us continue to serve you and our other patients, with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Benjamin A. Dubin, MD

Samuel Solomon, MD

Kimberly Schwerdtfer, N.P.-C

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Card**
If you have health insurance, we can't see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan or verify that it has already been faxed to us by your primary care physician.
- **Co-pay or Deductible** is collected at check in
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Parent or Legal Guardian must accompany patients who are minors**

BENJAMIN A. DUBIN, MD | SAMUEL SOLOMON, MD

103 S. GREENLEAF, SUITE J | GURNEE, IL 60031 | PHONE 847.662.8201 | FAX 847.662.8215



How did you find us?

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

PATIENT INFORMATION

Last Name: _____ PCP/Family Doctor: _____
First Name: _____ MI: _____ Patient Date of Birth: _____ Male Female
Preferred Name: _____ Marital Status: Single Married Divorced Widowed
("John", "Mr. Jones", etc.) Legally Separated Partner
Mailing Address: _____ Patient Social Security Number: _____
(If PO Box, complete Street Address below) Email: _____
City: _____ State: _____ Zip: _____ Employer: _____
Street Address: _____ Address: _____
(complete only if Mailing Address provided above is a PO Box) City: _____ State: _____ Zip: _____
City: _____ State: _____ Zip: _____ Work Phone:(_____) _____ Occupation: _____
Preferred Phone: (_____) _____ Cell Home Work Other: _____
May we leave a confidential voice mail on this phone? Yes No Cell Home Work Other: _____
Alternate Phone: (_____) _____
May we leave a confidential voice mail on this phone? Yes No

INSURANCE INFORMATION Self Pay

Primary Insurance: _____ ID#: _____ Policy Holder: <input type="checkbox"/> Patient (if not patient, complete information below) <input type="checkbox"/> Name: _____ DOB: _____ SS# _____ Relation _____ Address: _____ (if different from patient's) City: _____ State: _____ Zip: _____	Secondary Insurance: _____ ID#: _____ Policy Holder: <input type="checkbox"/> Patient (if not patient, complete information below) <input type="checkbox"/> 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: (_____) _____

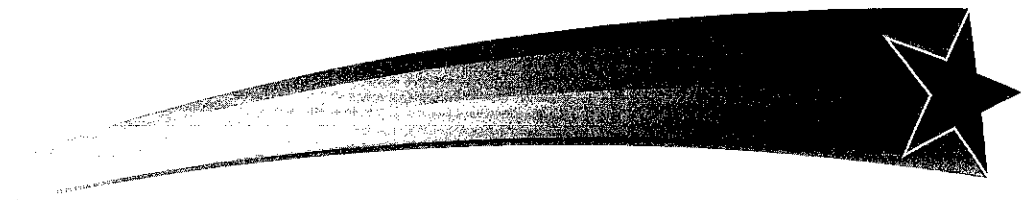
CONTACT IN CASE OF EMERGENCY: Check only if this person is **NOT** to be included in MEDICAL RELEASE section below.

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** _____



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

MEDICAL HISTORY

Patient: _____ **Reason for visit:** _____ **Appointment Date:** _____

Did a doctor's office send you to us for a specific problem? Yes No If YES, name of referring provider: _____

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

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

- | | |
|--|---|
| <input type="checkbox"/> Skin Cancer-Melanoma: _____ | <input type="checkbox"/> Psoriasis: _____ |
| <input type="checkbox"/> Skin Cancer-Other: _____ | <input type="checkbox"/> Eczema: _____ |
| <input type="checkbox"/> Other Cancers: _____ | <input type="checkbox"/> 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

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Other skin complaints | <input type="checkbox"/> Fever/chills/wt. change | <input type="checkbox"/> Itching | <input type="checkbox"/> Joint Aches |
| <input type="checkbox"/> Other systemic complaints | <input type="checkbox"/> Sun sensitivity | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> 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 missed appointment fee added to your account. 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.

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.

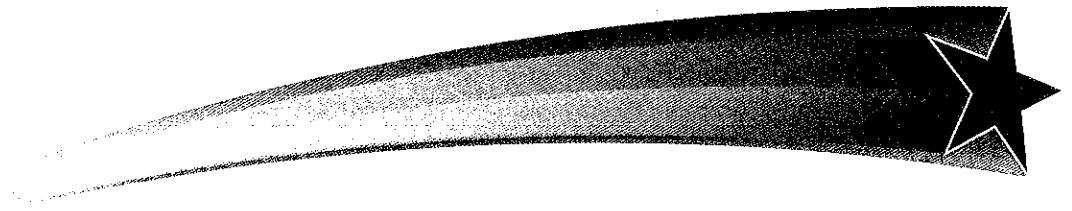
In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare 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: ____/____/____



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 due at the time of the visit will, of course, still be due at the time of service.

If you have any questions about this payment method, 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 (HAS, FSA, flex spend, etc)

Account Number _____ Security Code _____ Exp Date _____

Name on Card (please print): _____

Signature: _____ Date: _____

BENJAMIN A. DUBIN, MD | SAMUEL SOLOMON, MD

103 S. GREENLEAF, SUITE J | GURNEE, IL 60031 | PHONE 847.662.8201 | FAX 847.662.8215



Directions from the North:

- From I-94E take IL-21 Milwaukee Avenue Exit
- Turn **left** onto IL-21/Riverside Drive/Milwaukee Ave.
- Turn **right** onto Washington Street
- Turn **right** onto Tower Court (by the big clock tower)
- Turn **right** onto the 1st drive on the right
- Turn **left** onto the 1st drive on the right

Arrive at our building Suite J

Directions from the South:

- From I-94 W/Edens Expressway toward Milwaukee
- Keep **left** to take US-41 North via Exit 29 toward Waukegan
- Take the exit toward Washington Street
- Turn **left** onto Washington Street
- Turn **left** onto Tower Court (by the big clock tower)
- Turn **right** onto the 1st drive on the right
- Turn **left** onto the 1st drive on the right

Arrive at our building Suite J

Directions from the West:

- From IL-176
- Turn **left** onto Schank Avenue
(Schank Ave becomes IL-83/Ivanhoe Road)
- Turn **right** onto E. Peterson Rd.
- Turn **left** onto IL-21/N. Milwaukee Avenue
- Turn **right** onto Washington Street
- Turn **right** onto Tower Court (by the big clock tower)
- Turn **right** onto the 1st drive on the right
- Turn **left** onto the 1st drive on the right

Arrive at our building Suite J

