LUPTON DERMATOLOGY

MR# **Today's Date:**

Prefix ❑Mr. ❑ Mrs. ❑Miss ❑Ms. ❑Dr. **Preferred Name**:

Patient's Name:

First Middle Last

Address:

Street & Apt # City State Zip

SS#: Birthdate Age: Sex: ❑ Female ❑Male

Marital Status: Unspecified ❑ Single ❑ Married to: ❑ Other:

Home Phone: Work Phone: Ext: Cell Phone:

Preferred Contact: ❑Home ❑ Work ❑Cell ❑Email **E-mail Address:**

Any restrictions for contacting you? ❑No ❑ Yes If yes, please describe

Emergency Contact: Relationship to Patient: Phone#:

Race: ❑African-American ❑Asian ❑ American Indian/Alaska Native ❑Native Hawaiian or Other Pacific Islander ❑White

Ethnicity: ❑Hispanic ❑Non-Hispanic **Preferred Language:**

How did you hear about us? ❑ Dr. Dermatologist ❑ Dr. Primary Care ❑ Newspaper ❑ Patient Referral ❑ Website ❑ Yellow Pages Details:

Referring Dr.: **Primary Care Dr.:**

INSURANCE INFORMATION

Primary Ins.: Insured: Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB: SS#:

Secondary Ins.: Insured: Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB: SS#:

RESPONSIBLE PARTY

Name: Address:

Relation to Patient: Birth Date:

PHARMACY

Pharmacy: **Phone:** **Street Name/City/St/Zip:**

PERMISSION TO DISCUSS

Is there any other physician other than those listed above that you wish to have medical information sent to?

Name: Address:

With whom may we discuss your account?

Name:

Lupton Dermatology & Skin Care Center
An affiliate of
The Skin Surgery Center, PA

CONSENT FOR USE OR DISCLOSURE OF INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (HIPAA)

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by The Skin Surgery Center, P.A. in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review The Skin Surgery Center Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form.

The Skin Surgery Center reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If The Skin Surgery Center does change the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requisition the Notice from the Front Office Staff of The Skin Surgery Center.

I retain the right to request that The Skin Surgery Center further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Skin Surgery Center is not required to agree to such requested restrictions; however, if The Skin Surgery Center does agree to my requested restriction(s), such restrictions are then binding on The Skin Surgery Center.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to The Skin Surgery Center in writing. The revocation shall be effective *except* to the extent that The Skin Surgery Center has already taken action in reliance on the consent. *The Skin Surgery Center may refuse to treat you, if you do not sign this Consent Form* (except to the extent that The Skin Surgery Center has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

PHONE CONSENT: I AUTHORIZE THE PHYSICIANS AND STAFF OF THE SKIN SURGERY CENTER TO:

Leave a message on my answering machine or voice mail at home? ___Yes ___ No Tele#_____
Leave a message on my cell phone? ___Yes ___ No Tele#_____
Text message my cell phone? ___Yes ___ No Tele#_____
Leave a message at my place of employment? ___ Yes ___No Tele#_____
Discuss my medical condition with a member of my family or a friend? ___ Yes ___No Tele#_____

If yes, please print names: _____ Relationship_____
_____ Relationship_____
_____ Relationship_____

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ ____/_____/_____ Date_____/_____/_____
Signature of Patient Date of Birth

_____
Please Print Name

_____ _____ _____
Signing on behalf of Patient Please Print Name Relationship to Patient

CONSENT FOR MINOR TO PRESENT FOR TREATMENT
(If a patient is under 18 - A parent or Guardian must sign)

I,_____, give my consent for my son/daughter, _____

_____ to bring himself/herself to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's signature_____ Date_____

Witness_____ Date_____

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AUTHORIZATIONS AND CONSENTS FOR PRECERTIFICATION,
FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND RELEASE OF CLAIMS INFORMATION

Precertification & Financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to The Skin Surgery Center, (SSC), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to SSC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and SSC.

Authorization to Release Claims Information: I hereby authorize The Skin Surgery Center, their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits by or on behalf of any such person. I hereby authorize SSC, its employees and agents to act on my behalf in completing claims.

I HAVE READ AND FULLY UNDERSTAND THE PRECERTIFICATION & FINANCIAL RESPONSIBILITY AUTHORIZATIONS, ASSIGNMENT OF BENEFITS CONSENTS AND AUTHORIZATION TO RELEASE CLAIM INFORMATION PRINTED ON THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM. THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: _____ Date: _____/_____/_____

Patient's Printed Name: _____

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is as follows:

Signature of Authorized Representative: _____

Relationship to Patient: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Patient Name:	MR#:
Appointment Date:	Page 1
Chief Complaint: (Please write reason, symptoms, condition or diagnosis that prompts your appointment)	

Past Medical History

PERSONAL SKIN HISTORY	YES	NO	Yes - Details
Melanoma	☐	☐	
Non-melanoma skin cancer (e.g. Basal cell carcinoma, squamous cell carcinoma or other)	☐	☐	
Tanning bed use	☐	☐	
Blistering sunburns	☐	☐	
Abnormal moles	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
EYES, EARS, NOSE AN THROAT	YES	NO	Yes - Details
Glaucoma, cataracts, macular degeneration, or other eye disorder	☐	☐	
Cold sores (herpes infection)	☐	☐	
RESPIRATORY	YES	NO	Yes - Details
Asthma	☐	☐	
Lung disease (e.g. collapsed lung, interstitial lung disease, etc.)	☐	☐	
History of tuberculosis or positive PPD	☐	☐	
CARDIOVASCULAR	YES	NO	Yes - Details
Pacemaker / defibrillator	☐	☐	
Heart murmur	☐	☐	
Artificial heart valve	☐	☐	
High blood pressure	☐	☐	
High cholesterol	☐	☐	
ENDOCRINE	YES	NO	Yes - Details
Diabetes	☐	☐	
Thyroid disease	☐	☐	
GASTROINTESTINAL	YES	NO	Yes - Details
Inflammatory bowel disease (e.g. Ulcerative colitis or Crohn's)	☐	☐	
Hepatitis	☐	☐	
Liver disease	☐	☐	
Reflux (GERD) and/or stomach ulcers	☐	☐	
GENITORURINARY	YES	NO	Yes - Details
Kidney disease	☐	☐	

Patient Name:			**MR#:**
Appointment Date:			**Page 2**
MUSCULOSKELETAL	YES	NO	Yes - Details
Arthritis (please specify: osteoarthritis, rheumatoid arthritis, psoriatic arthritis, or other type)	☐	☐	
Artificial joint(s). If Yes, what year?	☐	☐	
ALLERGIC / IMMUNOLOGIC / INFECTIONS	YES	NO	Yes - Details
AIDS/ HIV infection	☐	☐	
Autoimmune disease (please specify if known)	☐	☐	
Prior Staph or MRSA infection	☐	☐	
Organ transplant recipient/immunosuppression	☐	☐	
Previous radiation therapy	☐	☐	
Previous or current chemotherapy	☐	☐	
History of ANY cancer	☐	☐	
HEMATOLOGIC	YES	NO	Yes - Details
Bleeding disorder (e.g. hemophilia, platelet disorder, etc.)	☐	☐	
Clotting disorder (e.g. blood clots, DVT, or pulmonary embolus, etc.)	☐	☐	
Lymphoma or leukemia	☐	☐	
NEUROLOGIC	YES	NO	Yes - Details
Demyelinating disease (e.g. multiple sclerosis, Guillain–Barré syndrome, etc.)	☐	☐	
Migraines (if yes, do you have an "aura" such as sound or light preceding the migraine?)	☐	☐	
Parkinson's disease	☐	☐	
Seizures	☐	☐	
Stroke	☐	☐	
PSYCHIATRIC	YES	NO	Yes - Details
Anxiety disorder	☐	☐	
Depression	☐	☐	
Bipolar disease or other mood disorder	☐	☐	
OTHER MEDICAL DISEASE (Please specify)			
PAST SURGICAL HISTORY	YES	NO	Yes - Details
Abdominal surgery	☐	☐	
Cosmetic surgery	☐	☐	
Eye surgery	☐	☐	
Ear/nose/throat surgery	☐	☐	
Heart surgery	☐	☐	
Spine or brain surgery	☐	☐	
Any other surgery? (If yes, please provide details)	☐	☐	
FEMALES ONLY: Have you had a hysterectomy or tubal ligation?	☐	☐	
FAMILY SKIN HISTORY	YES	NO	Which family members were affected? (Mother, Father, Grandmother, Grandfather, Brother, Sister, etc.)
Are you adopted?	☐	☐	
Acne	☐	☐	

Patient Name:			**MR#:**
Appointment Date:			**Page 3**
	YES	NO	
Eczema	☐	☐	
Psoriasis	☐	☐	
Melanoma	☐	☐	
Non-melanoma skin cancer	☐	☐	
Abnormal moles	☐	☐	
SOCIAL HISTORY	YES	NO	
Do you use alcohol?	☐	☐	
If yes, How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?	☐ unknown		
	☐ 0		
	☐ 1		
	☐ 2		
	☐ 3 or more		
Smoking Status:	☐ Current every day smoker	☐ Current some day smoker	
	☐ Former smoker	☐ Never smoker	
	☐ Smoker, current status unknown	☐ Unknown if ever smoked	
	☐ Heavy tobacco smoker	☐ Light tobacco smoker	
Started Date:			
Ended Date:			
	YES	NO	
Have you had the flu shot within the last year? (If yes, select an option below)	☐	☐	
Influenza immunization previously received at home.	☐	☐	Date:
Influenza immunization previously received at work.	☐	☐	Date:
If you're 65 or older; have you ever received a pneumonia vaccine? If Yes, date	☐	☐	Date:
OCCUPATION			
What is your occupation?			

MEDICATIONS – Are you currently taking any medications? ☐ Yes ☐ No **If yes, please complete section below.

Medication name	Dosage

Patient Name:	**MR#:**
Appointment Date:	**Page 4**

Are you allergic to any medications? ☐ Yes ☐ No ** If yes, please complete section below.

Medication name	Reaction

Thank you for completing your Past Medical History and Review of System forms. These will be included in your medical record.