



**Patient Information:** (Please complete using your name as listed on your insurance card. **PRINT CLEARLY.**)

First Name: \_\_\_\_\_ Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: M F  
Address: \_\_\_\_\_ Apt: \_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_  
Email: \_\_\_\_\_ @ \_\_\_\_\_  
Marital Status: Single Married Divorced Domestic Partner Widow  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
**STUDENTS ONLY:** (If over 18 years of age)  Part-time student  Full-time student

**Under a new federal law, the following questions are now required:**

|                       |                          |                                   |                          |                          |                            |                          |                          |
|-----------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| <b>Ethnicity:</b>     | <input type="checkbox"/> | <b>Race:</b>                      | <input type="checkbox"/> | <input type="checkbox"/> | <b>Preferred Language:</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hispanic or Latino    | <input type="checkbox"/> | Asian                             | <input type="checkbox"/> | Chinese                  | <input type="checkbox"/>   | English                  | Italian                  |
| Caucasian             | <input type="checkbox"/> | Caucasian                         | <input type="checkbox"/> | Filipino                 | <input type="checkbox"/>   | French                   | Mandarin                 |
| Other or Undetermined | <input type="checkbox"/> | Black or African American         | <input type="checkbox"/> | Japanese                 | <input type="checkbox"/>   | German                   | Spanish                  |
| Black                 | <input type="checkbox"/> | American Indian or Alaskan Native | <input type="checkbox"/> | Native Hawaiian          | <input type="checkbox"/>   | Vietnamese               |                          |
| Asian                 | <input type="checkbox"/> | Other                             | <input type="checkbox"/> | Multiracial              | <input type="checkbox"/>   |                          |                          |
| Decline to answer     | <input type="checkbox"/> | Undetermined                      | <input type="checkbox"/> | Pacific Islander         | <input type="checkbox"/>   |                          |                          |
|                       |                          | Decline to answer                 | <input type="checkbox"/> |                          |                            |                          |                          |

Do you have any impairment? (please circle): Visual Hearing Speech Learning Physical Language/Cultural **NO BARRIERS EXIST**   
Do you have any religious or cultural customs that our providers should know about? (please circle) : YES NO  
If yes, please describe: \_\_\_\_\_

**Person Responsible for Payment:**

First Name: \_\_\_\_\_ Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt: \_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_  
Relationship to patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_\_

**Insurance Information:** (All patients must provide a copy of their insurance card and proper ID at **every** visit.)

**Primary Insurance:** \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_  
Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M F  
Policy Holder's Employer: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_  
Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M F  
Policy Holder's Employer: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Contact #:** \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Co-payments and Deductibles:** Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. An administrative billing fee of \$10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances owing that are past due. I further acknowledge that I am responsible for the co-insurance and/or deductible under my health plan's agreement and should The Dermatology Group, PC be required to send me to a collection agency, I shall be responsible for the greater of \$50 collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy.

**Referrals:** If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, The Dermatology Group, PC **will reschedule** my appointment.

**Insurance Cards:** All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Cancellation Policy:** Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 48 hours of the appointment will result in a \$25.00 no-show fee. This fee is not reimbursable by your insurance company.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**HIPAA Policy:** Patients 18 years of age or older are protected under the Federal Health Insurance Portability and Accountability Act. This federal law prohibits any staff member of The Dermatology Group, P.C. from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition, obtain results or appointments for you, please list their name(s) below. Only individuals names listed will be provided with information. Should you wish to update the names provided, please ask the patient service representative at the front desk for a HIPAA form.

Name of Individual (please print)

Relationship to Patient

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Acknowledgement:** I acknowledge having received a copy of The Dermatology Group, P.C.'s Notice of Privacy Practice related to the Health Insurance Portability and Accountability Act of 1996.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian:** I certify that the information that I have provided is correct. I hereby assign to The Dermatology Group, PC, any insurance or third party payments for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Occupation: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_  
 Town Located: \_\_\_\_\_

**(TDG electronically transmits all prescriptions to pharmacy)**

**Have you had any of the following conditions in the past?**

|                                   |   |   |                         |   |   |
|-----------------------------------|---|---|-------------------------|---|---|
| Skin cancer                       | Y | N | Hepatitis/Liver disease | Y | N |
| Melanoma                          | Y | N | Lupus                   | Y | N |
| Atypical moles (dysplastic nevus) | Y | N | Herpes simplex          | Y | N |
| Basal cell carcinoma              | Y | N | Bleeding disorders      | Y | N |
| Squamous cell carcinoma           | Y | N | Crohn's/Colitis disease | Y | N |
| Actinic keratoses                 | Y | N | Heart valve replacement | Y | N |
| T-cell lymphoma                   | Y | N | Pacemaker               | Y | N |
| Other cancer                      | Y | N | Hip replacement         | Y | N |
| Diabetes                          | Y | N | Cataracts               | Y | N |
| Sarcoid                           | Y | N | Glaucoma                | Y | N |
| Heart disease                     | Y | N | Kidney/Renal disease    | Y | N |
| Stroke/TIA                        | Y | N | GYN problems            | Y | N |
| Seizures/Epilepsy                 | Y | N | HIV                     | Y | N |
| Thyroid disease                   | Y | N | AIDS                    | Y | N |

**Do you have any of the following?**

|                   |   |   |                        |   |   |
|-------------------|---|---|------------------------|---|---|
| Itchiness         | Y | N | Nose bleeds            | Y | N |
| Dry skin          | Y | N | Swelling in hands/feet | Y | N |
| Oily skin         | Y | N | Wheezing               | Y | N |
| Irritated lesions | Y | N | Abdominal pain         | Y | N |
| Changing lesions  | Y | N | Joint pain             | Y | N |
| Fever             | Y | N | Headache               | Y | N |
| Fatigue           | Y | N | Depression             | Y | N |
| Excessive sweat   | Y | N | Recent weight gain     | Y | N |
| Dry eyes          | Y | N | Recent weight loss     | Y | N |
| Itchy eyes        | Y | N | Swollen glands         | Y | N |

**Please identify any of the following that a family member may have had:**

|                |   |   |              |   |   |
|----------------|---|---|--------------|---|---|
| Skin cancer    | Y | N | Lupus        | Y | N |
| Melanoma       | Y | N | Other cancer | Y | N |
| Atypical moles | Y | N | Diabetes     | Y | N |
| Acne           | Y | N | Sarcoid      | Y | N |
| Eczema         | Y | N | HIV          | Y | N |
| Psoriasis      | Y | N | AIDS         | Y | N |

Do you have a "Living Will" or Advance Directives? Y N

Do you spend long hours in the sun? Y N

Have you ever had a blistering sunburn? Y N

Do you smoke? Y N Packs per day: \_\_\_\_\_

Do you drink alcohol? Y N Drinks per day: \_\_\_\_\_

Do you use illegal drugs? Y N Which drugs: \_\_\_\_\_

**Females:** Pregnant or nursing: Y N

Trying to get pregnant: Y N

|  |  |
|--|--|
| <b>Name of current medication(s)</b><br>_____<br>_____<br>_____<br>_____ | <b>What are you taking this for?</b><br>_____<br>_____<br>_____<br>_____ |
| <b>Medication Allergies:</b> _____                                       |  |

## **E-PRESCRIBE CONSENT FORM**

ePrescribe is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribe greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that The Dermatology Group, P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to The Dermatology Group, P.C. to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

### **Consent Accepted:**

**Patient Name** (Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Signature** \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### **Consent Denied:**

Signature \_\_\_\_\_

Date \_\_\_\_\_