PATIENT INFORMATION

Name: _____ Date of Birth: _____

Email: _____ Social Security #: _____

Cell Phone:_____ Home/Work Phone: _____

Preferred Contact Number & Method: _____ ☐ Text ☐ Email ☐ Cell ☐ Home

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

LOCAL ADDRESS: _____

OTHER ADDRESS: _____

Referred By: ☐ Friend ☐ Family ☐ Website/Internet ☐ TV ☐ Radio ☐ Print Ad ☐ Doctor:_____

Primary Care Doctor Name & Phone: _____

Emergency Contact Name & Phone: _____

Employer Name & Phone: _____

_____ FINANCIAL **POLICY for ALL PATIENTS**: Payment for services is due in full at the time service is provided. We respectfully request 24-hr advance notice if you need to cancel or reschedule – this is especially important for surgery and aesthetic procedures. Failure to provide notice of a need to cancel may result in charge for the missed appointment.

_____ FINANCIAL **POLICY for INSURANCE PATIENTS**: We will bill most insurances if provided with all required information, authorizations, documentation, and any required prior authorizations. Prior authorization may be required prior to scheduling surgery or other procedures. Co-payments, co-insurance and deductibles are collected the day of your service. Your insurance is a private agreement between you and your insurance. We do not routinely research why your insurance has not paid or paid less than anticipated. You may be responsible for the following:

- Non-covered services – any care not paid for by your insurance company under your coverage.
- Full Body Exam – periodic preventative health checks may or may not be covered under your policy; however, they may be recommended by your Provider.

☐ Y ☐ N → *Have you given us a copy of your Insurance Card(s)?*

1st INSURANCE NAME: _____ Are you the Primary Insured: ☐ Y ☐ N

if No, name of Insured is:_____ Relationship: _____

2nd INSURANCE NAME: _____Are you the Primary Insured: ☐ Y ☐ N

if No, name of Insured is:_____ Relationship: _____

Assignment of Insurance Benefits – please read and sign below:

"I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am untitled, private insurance, and any other health plans, to Advanced Dermatology and Skin Surgery Specialists, PA (dba Yag-Howard Dermatology and Aesthetic Center). This assignment remains in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment."

Signature: _____ Date:_____

MEDICAL HISTORY – please ✓ all that apply.

	Anxiety / Depression		Heart Disease		Cancer		Liver Disease
	Breathing Disorder		Hypertension		-type:		Hepatitis
	Diabetes		Stroke		-type:		Hyperthyroidism
	Autoimmune Disease		Defibrillator		Radiation Treatment		Hypothyroidism
	Lyme Disease		Pacemaker		Bone Marrow Transplant		Hepatitis
	HIV / AIDS		Bleeding Disorder		Arthritis		Renal Disease
	Pigment Disorder		Poor Wound Healing		Joint Replacement		Seizures
	Surgeries: skin /other						
Other:							
☐ *Check here if NONE of the above are applicable*							

SKIN HISTORY – please ✓ all that apply.

	Atypical Moles		Acne		Shingles		Eczema
	Basal Cell Carcinoma		AKs (Actinic Keratosis)		Genital Warts		Psoriasis
	Squamous Cell Carcinoma		Blistering Sunburns		Cold Sores		Scalp Conditions
	Melanoma		Poor Wound Healing				
Other:							
☐ *Check here if NONE of the above are applicable*							

MELANOMA HISTORY:

Location	When	From Whom May We Request Records?
		☐ *Check here if NONE of the above are applicable*

MEDICATION & VITAMIN HISTORY: -- please list what you are taking, dosage strengths and how often.

We can attach your list if you brought it.		
	☐ *Check here if NO medications or vitamins*	

YAG-HOWARD
DERMATOLOGY & AESTHETICS CENTER

ALLERGIES:_____

_____

_____ ☐ *Check here if NO ALLERGIES*

PHARMACY:

Name/Location: _____ Phone: _____

SOCIAL HISTORY – for care and treatment & Federally required for your electronic health record:

	Decline	YES	NO
Sun / UV Exposure			
- Wear sunglasses			
- Use sunscreen (SPF# ___)			
- Use tanning beds			
Tobacco			
- Number of packs per day			
- Quit? When?			
Do You Have Advanced Directives? *Examples: Living Will, Power of Attorney, Healthcare Proxy*			

	Decline	YES	NO
Driving restrictions			
Feel safe at home			
Use illicit drugs			
Sexual Activity			
- Safe sex			
- Multiple partners			
Alcohol Consumption			
- Frequency per week?			
- Episodes of 5 or more drinks per day in one year			

☐ *Check here if you DECLINE to provide ANY information*

FAMILY HISTORY – and relationship to you – parent(s), sibling(s) or grandparent(s):

Cancer (types)		Skin Conditions	
		Heart Disease	
Melanoma		Diabetes	
OTHER:	☐ *Check here if NO family history of illness*		

SHARING YOUR INFORMATION:

YES	NO	In the interest of ensuring comprehensive medical care, I give Advanced Dermatology and Skin Surgery Specialists PA (dba Yag-Howard Dermatology and Aesthetic Center) permission to:
		Leave a message at my Preferred Contact # concerning biopsy results, lab tests, or any other protected health information (PHI).
		Share my PHI with other health care providers, laboratories, pathology offices and related medical service providers as necessary.
		Share my PHI with insurance companies.
		Discuss my biopsy results, lab tests, or any other PHI with the following people: (NAME / RELATIONSHIP)
		-
		-
		-

HIPAA CONSENT (Health Insurance Portability and Accountability Act of 1996)**:**

In connection with the medical services that I am receiving from Yag-Howard Dermatology Center and its medical staff, I hereby authorize Yag-Howard Dermatology Center, its practitioners, and their respective agents to disclose any and all information concerning my medical condition and treatment (including, but not limited to super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, DNA samples or analyses, or other such information), including copies of applicable hospital and medical records to:

A. any third-party payor covering the medical services of the patient;
B. other health care professionals and institutions involved in the delivery of health care to the patient;
C. the proponent of any legally sufficient subpoena, or in response to a court order;
D. employees and agents of the practice, to the degree necessary to facilitate the provision of health care operations, services and payment for such services;
E. pharmacies; and
F. as otherwise required by law.

Signature: _____

PHOTO CONSENT

I further consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my practitioner and under such conditions and at such times as may be approved by my provider.
2. The photographs shall be taken by my practitioner or by a photographer approved by my provider.
3. The photographs shall be used for medical records and, if, in the opinion of my practitioner, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which my provider may deem proper in the interest of medical education, knowledge, or research. In such instances, however, it is specifically understood that in any such publication or use I shall not be identified by name and reasonable steps shall be taken to preserve my identity.
4. The aforementioned photographs may be modified or retouched in any way that my provider, in his/her discretion, may consider desirable.

Signature: _____

This consent is valid from the date executed until revoked in writing by the patient.

Signature: _____

IF YOU ARE NOT THE PATIENT, what is your Name & Relationship: _____

Thank you for completing this important information.
It helps us provide you with the very best care.