Asarch Center 2011

(Insurance can only be billed if information is complete)

Patient Information

Name____________________

Sex: M / F Date of Birth____________________ SSN____________________

Address____________________ Unit/Apt #____________________

City__________ State__________ Zip Code__________ Email Address____________________

Home #__________ Work #__________ Employer__________

Spouse____________________ Work #____________________

Guarantor Name ____________________ Relationship to pt ____________________

❑ Mother (if minor)____________________ Home #__________ Work #__________

❑ Father (if minor)____________________ ______Home #__________Work #__________

Primary Care Dr__________ Phone #__________ Referred by__________

Insurance Information

1st Insurance____________________ HMO POS PPO SELF INDEMNITY OTHER________

Insured ID #____________________ Group #____________________ Copay__________

Ins. Co. Address____________________City__________State____Zip Code__________

Policy Holder Name____________________ Relationship____________________

Sex: M / F Date of Birth____________________ SSN____________________

Address____________________ Unit/Apt #____________________

City____________________ State__________ Zip Code____________________

Home #__________Work #__________ Employer__________

2nd Insurance ____________________ HMO POS PPO SELF INDEMNITY OTHER________

Insured ID #____________________ Group #____________________ Copay__________

Ins. Co. Address____________________State__________Zip Code__________

Policy Holder Name____________________Relationship____________________

Sex: M / F Date of Birth____________________ SSN____________________

Address____________________ Unit/Apt #____________________

City____________________ State__________ Zip Code____________________

Home #__________Work #__________ Employer__________

Emergency Contact

Name____________________ Relationship____________________

Home #____________________ Work #____________________

I understand that this form must be complete in order for insurance to be billed. I consent to the release of medical information to my insurance company and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPPA). I authorize and request that any insurance benefits be paid directly to Asarch Center for Dermatology. I understand the financial policies of this practice and agree that I am responsible for the balance on my account for services rendered. Account balances that exceed 60 days will be charged a rebilling charge of $4.00/month. I understand that tissue removed will be sent to a laboratory for pathological examination which involves additional fees.

Signature____________________Date____________________

Health History

Date____________________

Name____________________________________

Skin cancer □Yes □No

Type: ___________________________

□Basal cell carcinoma

□Squamous cell carcinoma

□Malignant melanoma

Other types of cancer □Yes □No

Type: ___________________________

History of Radiation to face □Yes □No

Lung disease □Yes □No

Type:___________________________

Heart Disease □Yes □No

Type: ___________________________

□ Artificial Heart valve

□ Heart Murmur

□ Pacemaker

□ Defibrillator

Bleeding Disorders □Yes □No

Type: ___________________________

High Blood Pressure □Yes □No

Arthritis □Yes □No

Type: ___________________________

Artificial Joints □Yes □No

Type: ___________________________

Neurologic Disease □Yes □No

Type: ___________________________

Headaches □Yes □No

□Tension □Migraine

Sexually Transmitted Diseases □Yes □No

Type: ___________________________

Medications Currently Taking:

____

____

Auto-Immune disease □Yes □No

Type: ___________________________________

□ Lupus

□Rheumatoid Arthritis

□Hyper/ Hypothyroidism

HIV/AIDS □Yes □No

Liver disease □Yes □No

Type: __________________________________

□Hepatitis B

□Hepatitis C

Endocrine Disease □Yes □No

OB/GYN

□ Breast Feeding

□ Pregnant

□ Irregular menses

Eye Disease □ Yes □ No

Type: __________________________________

□ Glaucoma □ Cataracts

Seasonal Allergies □Yes □No

Family history of skin disease & medical problems

Type: ___________________________________

Social History

Smoke □Yes packs per day _____ □No

Alcohol □Yes Drinks per day_____ □No

Psychiatric history □Yes □No

□ Depression □ Other

Type: ___________________________________

Other Medical Problems

List: ___________________________________

____

Medication Allergies:

List: ___________________________________

_________________________________09/08br

ACKNOWLEDGEMENT

I, ____, acknowledge that I have received a copy of Asarch Center for Dermatology, Notice Regarding Privacy of Personal Health Information.

________________________________ ____________________
(Signature) (Date)