STEELE CREEK DERMATOLOGY

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Name: Mr Ms Mrs Dr _____
Last First Initial

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home #:_____Work #:_____Cell #:_____#Preferred:_____
Email:_____
Date of Birth:_____ Age:_____ Sex: F / M Marital Status: M / S / D / W
SSN:_____ Employer:_____ Student: Y / N

Preferred Language:_____ Race:_____ Ethnic Group:_____

RESPONSIBLE PARTY (If patient under 18 years of age)

Name: Mr Ms Mrs Dr_____
Last First Initial
Relationship of patient to the Responsible Party:_____ Employer: _____
Mailing Address:_____
Home Phone:_____Work:_____Cell:_____Preferred:_____
Email:_____ Date of Birth:_____
Age:_____ Sex: F / M SSN:_____ Marital Status: M / S / D / W

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name:_____
Name of Subscriber:_____Date of Birth:_____
Subscriber's ID#_____Group#_____ Subscriber's SSN:_____
Relationship of patient to the Subscriber_____
Secondary Insurance Name:_____
Name of Subscriber:_____ Date of Birth:_____
Subscriber's ID#_____Group#_____ Subscriber's SSN:_____
Relationship of patient to the Subscriber:_____

EMERGENCY CONTACT

Name:_____Relationship to patient:_____

Home Phone:_____Work:_____Cell:_____ #Preferred:_____

MEDICAL HISTORY AND INTAKE FORM

Patient: _____ **Date of Birth:** _____
Primary Care Physician Name and address_____
Pharmacy Name, Address, and Phone Number_____
How did you hear about us? Referring doctor _____
Family Friend Internet Insurance carrier Yellow Pages Newspaper ad Other
Reason for today's visit_____

CURRENT OR PAST PROBLEMS WITH: (PLEASE CHECK ALL THAT APPLY)

Anxiety	Coronary artery disease	Hyperthyroidism
Arthritis	Depression	Hypothyroidism
Asthma	Diabetes	Leukemia
Atrial fibrillation	End stage renal disease	Lung Cancer
BPH	GERD	Lymphoma
Bone marrow transplant	Hearing loss	Prostate Hyperplasia
Breast Cancer	Hepatitis	Prostate cancer
Breast cancer	High Blood Pressure	Radiation treatment
Colon cancer	HIV/AIDS	Seizures
COPD	High Cholesterol	Stroke
	Hyperplasia	Valve replacement
None	Other_____	

PAST SURGICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Appendix removed	Mechanical valve replacement	Prostate removed : cancer
Bladder removed	Biological valve replacement	Prostate biopsy
Mastectomy (R,L, Both)	Heart transplant	TURP (prostate)
Lumpectomy (R,L, Both)	Joint Replacement , Knee (R,L,B)	Skin biopsy
Breast biopsy (R,L, Both)	Joint Replacement, Hip (R,L, Both)	Basal cell cancer surgery
Breast Reduction	Joint Replacement within 2 years	Squamous cell surgery
Colectomy: Colon cancer	Kidney Biopsy	Melanoma surgery
Colectomy: Diverticulitis	Kidney removed (R, L)	Spleen removed
Colectomy: IBD	Kidney stone removal	Testicles removed (R,L,Both)
Gallbladder removed	Kidney transplant	Hysterectomy: Fibroids
Coronary artery bypass	Ovaries removed: Cyst	Hysterectomy: Uterine ca
PTCA	Ovaries removed: ovarian ca	**None**
Other_____	Ovaries removed: endometriosis	

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
history of melanoma		
breastfeeding or lactation		
problems with bleeding		
problems with healing		
problems with scarring (hypertrophic or keloid)		
yeast infections with antibiotics		
GI upset with antibiotics		
fainting		
immunosuppression		
changing mole		
rash		
hay fever		
wheezing		
MRSA		
pacemaker		
debrillator		
artificial joints within past two years		
artificial heart valve		
premedication prior to procedures		
allergy to adhesive		
allergy to topical antibiotic ointments		
blood thinners		
pregnancy or planning a pregnancy		
allergy to lidocaine		
rapid heart beat with epinephrine		

Other Symptoms:

SKIN DISEASE HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Acne	Hay Fever/Allergies
Actinic keratoses (pre-cancer)	Melanoma
Asthma	Poison ivy/oak
Basal cell skin cancer	Precancerous moles
Blistering sunburns	Psoriasis
Dry skin	Squamous cell carcinoma
Eczema	**None**
Flaking or itchy scalp	

Other_____

Do you wear Sunscreen? Yes No

If yes, what SPF?_____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative?_____

Any other family history:_____

CURRENT MEDICATIONS:

_____

_____

_____

MEDICATION ALLERGIES:

_____

_____

SOCIAL HISTORY: (Please circle all that apply)

Sexual History

Not sexually active	Sexually active with one partner	Sexually active with more than one partner
Illicit Drug Use	None	Drug use
Alcohol use	None 1-2 drinks per day	Less than 1 drink 3 or more drinks per day
Smoking Status	Current every day smoker Former smoker	Current some days smoker Never smoker

Other _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I am confirming that I have been informed of my rights to privacy regarding my Protected Health Information (PHI) to carry out treatment, payment and healthcare operations (TPO) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.**
- **Process insurance claims, insurance applications, and prescriptions.**
- **Conduct normal health care operations such as quality assessment and improvement activities.**

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information (PHI). I have been given the right to review and option to receive a copy of such notice. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used if disclosed to carry out treatment, payment, and healthcare operations (TPO), and I understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. If I do not sign this consent, Jennifer L. Helton, M.D. may decline to provide treatment to me.

With this consent, Steelecreek Dermatology may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out the TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and pathology results among others.

With this consent, Steelecreek Dermatology may mail to my home or other designated location any items that assist in carrying out TPO such as appointment reminders, insurance items, and calls regarding clinical care including laboratory and pathology results among others.

X _____

Patient name Patient or Authorized Signature Relationship to Patient Date

Please list any persons to whom your protected health information can be disclosed.

Name:_____Relationship_____

Name:_____Relationship_____

General Responsibility: Payment is required for all services at the time they are rendered unless you are covered under an insurance policy in which we participate. For those patients, applicable co-payments, deductibles, and or coinsurance will be collected at the time of service. Please make sure your billing information is complete and accurate. You must bring your updated insurance card with you. You may be billed separately for laboratory services. Many insurance plans may require you to have: specific doctors, pre-certification, and referrals. You are responsible to know the details for your insurance plan. We accept payment in the form of cash, check or credit card. There is a $30.00 charge for a returned check. I have read and understand the financial policy statement. I agree to make prompt payment to Steelecreek Dermatology when billed for any and all charges not covered or paid by valid insurance benefits. I authorize payment directly to Steelecreek Dermatology 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.

Social Security Number Policy: We do require a Social Security Number for the patient and insurance policy holder. Once it is placed into our computer system the Social Security Number will be deleted all but the last four digits. If the patient does not wish to provide us with his/her Social Security Number they will be asked to be a self-pay patient and will need to pay at the time of service rendered. This is for a collection purpose only. If you have questions regarding this policy please ask to see the Office Manager.

Non-covered Services: Services that your insurance company considers cosmetic or not medically necessary will not be reimbursed by your insurance company. Payment in full is due at the times of service (example: skin tags, milia/cysts, normal moles, benign asymptomatic keratoses, oil glands, blood vessels, molluscum, and some warts).

Collection Fee's: Patient's balance over 60 days may occur finance charges. Balance over 90 days may be sent to collection agency George Brown Associates, INC. , with **$40.00 collection fee**.

Account Balances: We will send monthly statements for unpaid balances. If your account has a credit balance, we will first apply any credit to other unpaid dates of services. Otherwise, we will issue a refund check for the credit after the clinical course of treatment is completed. No refund will be sent for a credit balance that is less than $2.00.

Missed and Late Appointments: Please call 24 hours in advance to cancel an appointment. Missed appointments & same day cancellations will result in a **$60.00** charge. Missed procedure/cosmetic appointments & same day cancellations will result in a **$100.00** charge. If you arrive 15 minutes late for your appointment you may be asked to reschedule; this may result as a missed appointment charge.

X _____

Patient Patient's signature or Responsible party Relationship Date

Permission to Treat a Minor (Age<18 years of age): A parent or guardian must be present with a patient under the age of 18 for the first visit and any subsequent visits in which a procedure is performed. The parent/guardian grants permission to Steelecreek Dermatology to see the minor without their presence for standard medical office visits. I have the legal right to select and authorize health care services for this minor.

X _____

Patient Responsible party signature Relationship Date

_____

Witnessed Date