STEELE CREEK DERMATOLOGY

Name: Mr Ms Mrs Dr _____
(Last) (First) (Nickname)

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 to patient:_____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 to patient:_____

Secondary Insurance Name:_____

Name of Subscriber:_____Date of Birth:_____

Subscriber's ID#_____Group#_____Subscriber's SSN:_____

Relationship to patient:_____

EMERGENCY CONTACT

Name:_____Relationship to patient:_____

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

ALL FORMS MUST BE FILLED OUT

Patient:_____ **Date of Birth:** _____

MEDICAL HISTORY AND INTAKE FORM

Primary Care Physician_____
(Name) (Telephone)

Pharmacy_____
(Name) (Telephone)

Referring Physician_____
(Name) (Telephone)

How did you hear about us? 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
Cold Sores	HIV/AIDS	Seizures
Colon cancer	High Cholesterol	Stroke
COPD	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)

Ages 6 months and older:	Did you receive your flu vaccine this year?	Yes	No
Ages 65 years and older:	Did you receive your pneumonia vaccine?	Yes	No
	Do you have a living will?	Yes	No
	Do you have a health care proxy?	Yes	No

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	Less than 1 drink
	1-2 drinks per day	3 or more drinks per day
Smoking Status	Current every day smoker	Current some days smoker
	Former smoker	Never smoker

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 of1996 (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 maycontact 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, Steele Creek 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 practicein 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, Steele Creek 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_____

Patient Financial Policy

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. You must bring your updated insurance card with you and 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. 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 Steele Creek Dermatology when billed for any and all charges not covered or paid by valid insurance benefits. I authorize payment directly to Steele Creek 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.

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.

Collection Fee's: Patient's balance over 60 days may occur finance charges. Balance over 90 days will be sent to the collection agency, George Brown Associates, INC. , with **$40.00 processing fee**.
(Three statements and one courtesy call for payment and then the account is sent to collections.)

Missed and Late Appointments: Cancellations require a 24 hour advance notice. Any appointment that is scheduled on the same date of service requires a minimum 1 hour cancellation notice. If you arrive 15 minutes late for your medical appointment and/or 5 minutes late for your cosmetic appointment you may be asked to reschedule; this may result as a missed appointment charge. In addition, families who have a no-show history consisting of 2 or more no-shows for multiple 12-month periods will be considered for dismissal at the discretion of the medical providers. Once dismissed, emergency medical treatment will be offered within the first 30 days of dismissal. Double header appointments (multiple appointments per person/multiple family member appointments scheduled together) will be subject to **multiple** no-show fees. Patients who no-show for a double header appointments may be restricted from scheduling double header appointments in the future.

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.**

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 Steele Creek 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