HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

Office Use Only
Chart #: _____
Appt Date: _____

Patient Information Form

Name: _____ **Nickname**: _____ **Date of Birth:** _____
First MI Last

Marital Status (circle one): Minor / Single / Married / Widowed / Divorced / Separated

SSN#: _____ **Place of Birth (City, State, Zip):** _____

Birth Sex (Circle one): Male / Female **Preferred Pronoun:** He / She / They

Gender Identity: Male / Female / Transgender Male / Transgender Female / Genderqueer / Other: _____

Ethnic Group (circle one): Hispanic or Latino / Not Hispanic or Latino

Race (circle one): White / Black/African / American Indian / Asian / Native American / Hispanic / Other

Preferred Language: _____

Emergency Contact

Name _____ **Relationship**: _____

Primary Phone: _____ Alternate **Phone**: _____

Home Phone Number: _____ **Cell Phone Number:** _____

Preferred Contact: Phone / Text / Email

Email Address: _____ ☐ ***Check box to receive e-mail alerts and updates***

Mailing Address: _____ **City/State**: _____ **Zip Code:** _____

Employer: _____ **Occupation:** _____

Primary Doctor: _____ **Referring Doctor:** _____

Preferred Pharmacy: _____ **City:** _____

IF THE PATIENT IS A MINOR OR DEPENDENT, COMPLETE THIS SECTION:

Primary Parent's Name: _____ **DOB**: _____
First MI Last

Street Address: _____ **City/State**: _____ **Zip Code**: _____

SSN#: _____ **Primary Phone**: _____

Patient lives with (circle one): Both parents / Mother / Father Other: _____

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

☐ If I choose not to accompany my minor child or dependent to his/her follow-up appointments, I authorize the primary provider to perform treatments and/or procedures necessary to deliver appropriate healthcare. I understand it may also include prescription of medication, administration of local anesthesia, application of liquid nitrogen, as well as other minor procedures.

☐ Either I, or the person(s) listed below will accompany my minor child or dependent to his/her follow-up appointments. I understand if I or the listed person(s) do not accompany him/her, he/she will not be seen. **Additional Person(s):** _____

_____

Parent or Guardian Signature: _____ **Date:** _____

TO BE COMPLETED FOR ALL MEDICARE PATIENTS ONLY

1. Are you a veteran? **YES NO**
   a. Did the VA refer you here for treatment? **YES NO**
   b. Do you have a VA "fee basis" ID card? **YES NO**
2. Do you have a Federal Black Lung Card? **YES NO**
3. Is this medical condition due to an accident of any kind? **YES NO**
   If yes, was it: __ Work related; __ Auto; __ Injured in own home; Other: _____
4. Are you covered by an employer's health insurance through your own employment or that of a family member? **YES NO**
   If yes, does that employer have more than 20 employees? **YES NO**
5. Have you recently joined a Medicare Advantage Plan? **YES NO**
   If yes, identify: _____
6. Are you covered by a commercial HMO/PPO, which makes Medicare secondary insurance? **YES NO**

It is the policy of this office to review the accuracy of this information annually.

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Heartland Dermatology Center, PA for any services furnished to me by their providers. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature: _____ **Date**: _____

MEDIGAP PAYMENT AUTHORIZATION (Secondary Insurance)

I hereby authorize payment of my Medigap benefits from _____ to Heartland Dermatology Center, PA for all claims on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient Signature: _____ **Date**: _____

INSURANCE AUTHORIZATION AND PAYMENT POLICY

Primary Insurance: _____ **Secondary Insurance**: _____

Policy #: _____ **Policy #:** _____

Policy Holder Name: _____ **Policy Holder**: _____

Policy Holder DOB: _____ **Policy Holder DOB**: _____

1. I understand Heartland Dermatology Center is a participating provider with BC/BS, Medicare, PHC, Coventry, WPPA, UHC Kancare, United Healthcare, HPK Network, and TriCare. I am responsible for any amounts not covered by any insurance or other party.
2. I understand that all co-pays are due at time of service.
3. I understand I may request a payment plan prior to seeing the provider.
4. I request that payment of benefits be made on my behalf to Heartland Dermatology Center for any services furnished by their providers.
5. I hereby authorize Heartland Dermatology Center to furnish information to insurance carriers concerning my illness and treatments.
6. I understand and verify all information is correct to the best of my knowledge.
7. **TRICARE PATIENTS**: If a referral is required, it is your responsibility to ensure our office receives this prior to your appointment.
8. **ALL OTHER INSURANCES**: If our office is not assigned or contracting with your insurance company, you will be required to pay for all services rendered to you. It is your responsibility to check with your insurance company prior to your appointment.

Patient signature: _____ **Date**: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

1. I acknowledge that I have had an opportunity to review and or/received Heartland Dermatology Center's "Notice of Privacy Practices."
2. I consent to Heartland Dermatology Center's use and disclosure of my personal health information to carry out treatment, payment and healthcare options unless I have determined to pay for services in full at time of service.
3. I understand this means Heartland Dermatology Center may call and leave a message on voicemail or in person in reference to any items that assist in meeting my healthcare needs, such as appointment reminders, insurance items, laboratory results, clinical care information, among others. I also understand Heartland Dermatology Center may also mail items to my home or other designated location such as appointment reminders, statements, brochures, and other items.
4. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I understand if I do not sign this consent, Heartland Dermatology Center may decline to provide treatment to me.
5. **I WISH TO ALLOW THE FOLLOWING PERSON(S) TO ACCESS ANY INFORMATION CONCERNING MY HEALTHCARE:**
   _____ Patient must initial: _____

Patient signature: _____ **Date**: _____

Patient Name: _____ DOB: _____

Office Use Only
Chart #: _____
Appt Date: _____

HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

Intake and History Form

What is the main concern for your visit today? _____

What areas of your body are affected? _____

How long have you had this concern? _____

Symptoms (circle all that apply): pain itch bleeding enlargement spreading burning redness embarrassment blistering other: _____

What oral medications have you tried for this concern? _____

What topical medications (prescription or OTC) have you tried? _____

List any other treatments you have used: _____

Past Medical History

Select any of the following medical conditions that you currently have or have had:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia
- ☐ Cerebrovascular Accident (CVA)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Disease caused by COVID-19
- ☐ Elevated Blood Pressure
- ☐ End Stage Renal Disease
- ☐ Epilepsy
- ☐ Hearing Loss
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis (Type): _____
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Transplant of Bone Marrow
- ☐ Seizures
- ☐ Stroke
- ☐ Transplant (Organ): _____
- ☐ Other: _____ _____

Past Surgical History

Select any of the following surgical procedures that you have had:

- ☐ Rectum: Abdominoperineal resection (APR)
- ☐ Joint replacement: Knee (Right / Left / Both)
- ☐ Heart: Coronary Artery Bypass Graft (CABG)
- ☐ Kidney: Kidney Transplant
- ☐ Appendix (Appendectomy)
- ☐ Gallbladder (Cholecystectomy)
- ☐ Colon (Colectomy)
- ☐ Liver (Hepatectomy)
- ☐ Heart: Percutaneous Transluminal Coronary Angioplasty (PTCA)
- ☐ Heart: Tissue Graft Heart Valve Replacement
- ☐ Prostate: Transurethral Prostatectomy (TURP)
- ☐ Hysterectomy
- ☐ Rectum: Lower Anterior Resection
- ☐ Heart: Mechanical Heart Valve Replacement
- ☐ Kidney: Kidney Stone Removal
- ☐ Prostate: Prostatectomy
- ☐ Joint Replacement: Hip (Right / Left / Both)
- ☐ Spleen: Splenectomy
- ☐ Kidney: Nephrectomy
- ☐ Heart Transplant
- ☐ Liver Transplant
- ☐ Other: _____

Patient Name: _____ DOB: _____

Skin Disease History

Have you had any of the following:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Dry Skin (Asteatosis Cutis)
- ☐ Basal Cell Skin Cancer
- ☐ Poison Ivy
- ☐ Precancerous (Dysplastic)
- ☐ Moles
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever / Allergies
- ☐ Psoriasis
- ☐ Malignant Melanoma
- ☐ Squamous Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Flaking or Itching 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 Malignant Melanoma, Squamous Cell Carcinoma (SCC)? ◯ **YES** ◯ **NO**

If yes, which relative? _____

Medications

List all current medications or bring a written medication list (prescription, OTC medications and supplements) including dose and frequency:

Medication Name	Dose	Frequency

Allergies

List all allergies to medications

_____

_____

Patient Name: _____ DOB: _____

Social History

Smoking Status (Choose one)

- ☐ Current everyday smoker
- ☐ Current occasional smoker
- ☐ Cigar smoker
- ☐ Former smoker
- ☐ Never smoked

Alcohol Intake (Choose one)

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1 to 2 drinks per day
- ☐ 3 or more drinks per day

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Immunizations

For patients 65 and older, have you received the Pneumococcal (Pneumovax) vaccine? ◯ YES ◯ NO

For patients 50 and older, have you received the Shingles (Zostavax) vaccine? ◯ YES ◯ NO

For all patients, have you received the Influenza vaccine this flu season? ◯ YES ◯ NO

Review of Systems

Are you currently or have you recently experienced any of the following (mark all that apply):

- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Fever or chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cough
- ☐ Shortness of breath
- ☐ Unintentional weight loss
- ☐ Weight gain
- ☐ Depression
- ☐ Anxiety
- ☐ Pain/burning on urination
- ☐ New onset of joint aches
- ☐ Numbness/weakness

Alerts

Select any of the following that you have (mark all that apply):

- ☐ Allergy to Adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to Topical Antibiotic Ointment
- ☐ Artificial Heart Valve
- ☐ Artificial Joint within the past 2 years
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ MRSA
- ☐ Premedication Prior to Procedures
- ☐ Rapid Heartbeat with Epinephrine
- ☐ Pregnant
- ☐ Planning Pregnancy
- ☐ Breastfeeding

_____ _____

Patient or Patient Representative Signature **Date**

_____ _____

Health Care Provider Signature **Date**