



Office Use Only
Chart #: _____
Appt Date: _____

### Patient Information Form

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
First MI Last

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Sex: \_\_\_\_\_ SSN#: \_\_\_\_\_

Email Address: \_\_\_\_\_ *By providing your email, you agree to receive communication including a company newsletter. If you wish to opt-out of this indicate here. No, thanks*

Phone Number (home): \_\_\_\_\_ Phone Number (cell): \_\_\_\_\_

Phone Number (work): \_\_\_\_\_ Employer: \_\_\_\_\_

Preferred Contact: Phone / Text / Email Preferred Language: \_\_\_\_\_

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

Ethnic Group (circle one): Hispanic or Latino / Not Hispanic or Latino Preferred Pronoun: He / She / They

Gender Identity: Male / Female / Transgender Male / Transgender Female / Genderqueer / Other: \_\_\_\_\_

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

Insured Party Name: \_\_\_\_\_ Insured Party Employer and Phone: \_\_\_\_\_

Responsible Party (Guarantor) Name: \_\_\_\_\_ Guarantor DOB: \_\_\_\_\_

Guarantor Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Guarantor Primary Phone: \_\_\_\_\_ Guarantor Work Phone: \_\_\_\_\_

**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#: \_\_\_\_\_ Employer: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

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

*If the legal guardian is unable to accompany the minor patient to their appointment, who else may accompany the patient to their appointment?* \_\_\_\_\_

**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 this will include evaluation and management for the presenting problem. I understand it may also include prescription of medication, administration of local anesthesia, application of liquid nitrogen, as well as other minor procedures.

I will accompany my minor child or dependent to his/her follow-up appointments. I understand if I do not accompany him/her, he/she will not be seen.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Emergency Contact**

Nearest Friend or Relative NOT living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

*Advanced Practice Providers (APPs): This office employs Nurse Practitioners and Physician Assistants. Occasionally and/or routinely your visit will encompass evaluation/treatment by our Advanced Practice Providers as either a component of your visit, or, if necessary, in place of the physician on staff. Our APP's work closely with and are supervised by our physician in all aspects of your care.*

**PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE**

**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 Holder:** \_\_\_\_\_ **Policy Holder:** \_\_\_\_\_

**Policy Holder SSN#:** \_\_\_\_\_ **Policy Holder SSN#:** \_\_\_\_\_

**Policy Holder DOB:** \_\_\_\_\_ **Policy Holder DOB:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

1. I understand Heartland Dermatology Center is a participating provier 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 regarding our contract 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:** \_\_\_\_\_



### Intake and History Form

Patient Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
Place of Birth (City, State and Zip): \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Primary Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

### Preferred Pharmacy

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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: \_\_\_\_\_  
Which of these products have been helpful? \_\_\_\_\_

### Past Medical History

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Adverse anesthesia outcome         | <input type="checkbox"/> Elevated Blood Pressure  | <input type="checkbox"/> Breast Cancer                  |
| <input type="checkbox"/> Anxiety                            | <input type="checkbox"/> End Stage Renal Disease  | <input type="checkbox"/> Colon Cancer                   |
| <input type="checkbox"/> Arthritis                          | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Prostate Cancer                |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Esophageal Reflux (GERD) | <input type="checkbox"/> Paralysis                      |
| <input type="checkbox"/> Atrial Fibrillation                | <input type="checkbox"/> Hearing Loss             | <input type="checkbox"/> Pneumothorax                   |
| <input type="checkbox"/> Benign Prostatic Hyperplasia (BPH) | <input type="checkbox"/> Heart Valve Disorder     | <input type="checkbox"/> Pulmonary Embolism             |
| <input type="checkbox"/> Bipolar Disorder                   | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Radiation Treatment            |
| <input type="checkbox"/> Blood Coagulation Disorder         | <input type="checkbox"/> Hypercholesterolemia     | <input type="checkbox"/> Rheumatoid Arthritis           |
| <input type="checkbox"/> Cerebrovascular Accident (CVA)     | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Transplant of Bone Marrow      |
| <input type="checkbox"/> COPD                               | <input type="checkbox"/> Hypothyroidism           | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Coronary Artery Disease            | <input type="checkbox"/> Hepatitis (Type): _____  | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT)         | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Congestive Heart Failure (CHF) |
| <input type="checkbox"/> Depression                         | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Transplant (Organ): _____      |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Lupus erythematosus      | <input type="checkbox"/> Other: _____                   |
| <input type="checkbox"/> Disease caused by COVID-19         | <input type="checkbox"/> Lymphoma                 | _____   |
| <input type="checkbox"/> Easy Bruising                      | <input type="checkbox"/> Lung Cancer              | _____   |

## Past Surgical History

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

- |  |   |
|--|---|
| <input type="checkbox"/> Rectum: Abdominoperineal resection (APR)                        | <input type="checkbox"/> Rectum: Lower Anterior Resection             |
| <input type="checkbox"/> Joint replacement: Knee (Right / Left / Both)                   | <input type="checkbox"/> Breast: Lumpectomy (Right / Left / Both)     |
| <input type="checkbox"/> Breast: Biopsy of Breast  | <input type="checkbox"/> Breast: Mastectomy (Right / Left / Both)     |
| <input type="checkbox"/> Prostate: Biopsy of Prostate                                    | <input type="checkbox"/> Heart: Mechanical Heart Valve Replacement    |
| <input type="checkbox"/> C-Section   | <input type="checkbox"/> Ovaries (Oophorectomy)                       |
| <input type="checkbox"/> Lung: Complete Excision (Right / Middle / Left)                 | <input type="checkbox"/> Brain Operation                              |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Graft (CABG)                      | <input type="checkbox"/> Pancreas: Pancreatectomy                     |
| <input type="checkbox"/> Kidney: Kidney Transplant                                       | <input type="checkbox"/> Kidney: Kidney Stone Removal                 |
| <input type="checkbox"/> Stomach: Gastrectomy  | <input type="checkbox"/> Liver: Portosystemic Shunt Operation         |
| <input type="checkbox"/> Spinal Surgery  | <input type="checkbox"/> Prostate: Prostatectomy                      |
| <input type="checkbox"/> Ovaries: Tubal Ligation   | <input type="checkbox"/> Joint Replacement: Hip (Right / Left / Both) |
| <input type="checkbox"/> Appendix (Appendectomy)   | <input type="checkbox"/> Hernia repair (Type: _____)                  |
| <input type="checkbox"/> Gallbladder (Cholecystectomy)                                   | <input type="checkbox"/> Small intestine resection                    |
| <input type="checkbox"/> Colon (Colectomy)   | <input type="checkbox"/> Spleen: Splenectomy                          |
| <input type="checkbox"/> Esophagus (Esophagectomy)                                       | <input type="checkbox"/> Stomach: Total Gastrectomy                   |
| <input type="checkbox"/> Liver (Hepatectomy)   | <input type="checkbox"/> Kidney: Nephrectomy                          |
| <input type="checkbox"/> Heart: Percutaneous Transluminal Coronary<br>Angioplasty (PTCA) | <input type="checkbox"/> Testicle: Orchidectomy                       |
| <input type="checkbox"/> Heart: Tissue Graft Heart Valve Replacement                     | <input type="checkbox"/> Heart Transplant                             |
| <input type="checkbox"/> Bladder (Cystectomy)  | <input type="checkbox"/> Liver Transplant                             |
| <input type="checkbox"/> Prostate: Transurethral Prostatectomy (TURP)                    | <input type="checkbox"/> Other:                                       |
| <input type="checkbox"/> Hysterectomy  | _____   |
| <input type="checkbox"/> Kidney Biopsy   | _____   |
| <input type="checkbox"/> Laparoscopy   | _____   |
| <input type="checkbox"/> Lung: Lobectomy (Upper Lobe: Right / Left)                      | _____   |
| <input type="checkbox"/> Lung: Lobectomy (Lower Lobe: Right / Left)                      | _____   |

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## Skin Disease History

Have you had any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Acne                               | <input type="checkbox"/> Eczema                    | <input type="checkbox"/> Blistering Sunburns |
| <input type="checkbox"/> Actinic Keratosis                  | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Other:              |
| <input type="checkbox"/> Dry Skin (Asteatosis Cutis)        | <input type="checkbox"/> Hay Fever / Allergies     | _____  |
| <input type="checkbox"/> Basal Cell Skin Cancer             | <input type="checkbox"/> Malignant Melanoma        | _____  |
| <input type="checkbox"/> Poison Ivy                         | <input type="checkbox"/> Flaking or Itchy Scalp    | _____  |
| <input type="checkbox"/> Precancerous (Dysplastic)<br>Moles | <input type="checkbox"/> Psoriasis                 | _____  |
|   | <input type="checkbox"/> Squamous Cell Skin Cancer | _____  |

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?  YES  NO If yes, which relative? \_\_\_\_\_

Do you have a family history of Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC)?  YES  NO  
If yes, which relative? \_\_\_\_\_

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## Social History

### Smoking Status (Choose one)

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

### 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? \_\_\_\_\_

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## Immunizations

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

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

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## Review of Systems

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Night sweats              | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Cough                     | <input type="checkbox"/> Anxiety                   |
| <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Pain/burning on urination |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> New onset of joint aches  |
| <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Weight gain               | <input type="checkbox"/> Numbness/weakness         |

## Alerts

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

- |   |  |
|---|--|
| <input type="checkbox"/> Allergy to Adhesive                      | <input type="checkbox"/> Pacemaker                         |
| <input type="checkbox"/> Allergy to Lidocaine                     | <input type="checkbox"/> MRSA                              |
| <input type="checkbox"/> Allergy to Topical Antibiotic Ointment   | <input type="checkbox"/> Premedication Prior to Procedures |
| <input type="checkbox"/> Artificial Heart Valve                   | <input type="checkbox"/> Rapid Heartbeat with Epinephrine  |
| <input type="checkbox"/> Artificial Joint within the past 2 years | <input type="checkbox"/> Pregnant                          |
| <input type="checkbox"/> Blood Thinners                           | <input type="checkbox"/> Planning Pregnancy                |
| <input type="checkbox"/> Defibrillator                            | <input type="checkbox"/> Breastfeeding                     |

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Patient or Patient Representative Signature

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Date

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Health Care Provider Signature

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Date