Patient Information

First Name		**Middle Name**		**Last Name**
Sex	**Marital Status**	**Date of Birth**		**Social Security Number**
Patient's Address		**City**	**State**	**Zip**
Home Phone		**Cell Phone**		
Email Address				
Primary Care Physician		**Primary Care Phone**		
Preferred Pharmacy	**Pharmacy Address**		**Pharmacy Phone**	
Have you received a pneumonia vaccination? Yes / No				

Emergency Contact (s) Authorized to Give/Receive Medical Information/Treatment Plans

Name	**Relationship**	**Phone #**
Name	**Relationship**	**Phone #**

***Please indicate if it is okay for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health.**

Patient/Legal Guardian Signature _____Phone #_____

BILLING, NO-SHOW, AND CANCELLATION FEES

I understand that I am responsible for knowing the details of my coverage and health insurance policy. Further, I understand that I am responsible for all co-pays, co-insurances, and deductibles as specified by my health insurance policy. I also understand that I am responsible for knowing when my appointment is scheduled and for showing up to the appointment promptly.

I understand that my health insurance company will be billed for services provided today and in future visits, and that it is my responsibility to ensure that any payments are remitted to Islandwide Dermatology in a timely fashion. In the event that any additional out of pocket payment is due after my health insurance reconciles a claim, Islandwide Dermatology will send 2 statements to the mailing address which I have provided. I acknowledge that the address provided is one at which I routinely receive and check my mail. If my address changes, I understand that it is my responsibility to advise Islandwide Dermatology of same.

After 2 statements have been sent to this address, if payment is not received by Islandwide Dermatology within 30 days of the last statement, I hereby authorize Islandwide Dermatology to charge my credit card, which I agree to leave on file, up to $75.00. I understand and acknowledge that this will only occur after 2 statements have been sent to my mailing address and I have failed to pay the bill for which I am responsible.

I understand that if I fail to show for my appointment without canceling it that I will be charged a no-show fee of $75.00 without any warning. I acknowledge that it is my responsibility to call and cancel any appointment which I have scheduled and cannot make prior to the appointment in order to avoid this penalty. I understand also that if I repeatedly cancel appointments or fail to show for them that I may be discharged from the practice.

Patient/Legal Guardian Signature _____DATE:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, hereby authorize IslandWide Dermatology, PC, and its employees, to release and disclose all or any part of my medical records to any entity which is, or may be liable, for all or part of the provider charges. I authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office, and/or its employees, to release via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care. I authorize and request that payment of any third party or insurance company benefits be made directly to IslandWide Dermatology for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

Patient/Legal Guardian Signature _____Date:_____

CONSENT FOR TREATMENT

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and its healthcare providers.

Patient/Legal Guardian Signature _____Date:_____

*Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.

*Some contract Health Plans (HMO, PPO, IPA, etc.) require a co-payment at the time of Service-Please have this ready prior to your visit as well as any current balance due. If copay is past due at the time of visit, patient may be required to reschedule the appointment.
*Patient is responsible for all lab work and must be prepared to tell the staff which lab their insurance requires them to use. If presenting new insurance on the day that labs are drawn, the patient should inform the patient person drawing their labs. We will not be able to make changes to the lab company once the lab work leaves our office for processing.

Patient/Legal Guardian Signature _____Date:_____

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounding to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient/Legal Guardian Signature _____Date:_____

ISLANDWIDE DERMATOLOGY
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Past Medical History: Please circle/check all that apply; if none apply, please circle/check *NONE* below the table

Anxiety	Disease Caused by 2019-nCoV	Hypothyroidism
Arthritis	Elevated Blood Pressure	Inflammatory disease of liver
Asthma	End Stage Renal Disease	Leukemia
Atrial Fibrillation	Epilepsy	Malignant Lymphoma
Benign Prostatic Hyperplasia	Gastroesophageal Reflux Disease	Malignant Tumor of Lung
Cerebrovascular Accident	H/O: Hypertension	Malignant Tumor of Breast
Chronic Obstructive Lung Disease	Hearing Loss	Malignant Tumor of Colon
Coronary Arteriosclerosis	Human Immunodeficiency Virus Infection	Malignant Tumor of Prostate
Depressive Disorder	Hypercholesterolemia (High Cholesterol)	Radiation Therapy Treatment Management
Diabetes Mellitus	Hyperthyroidism	Transplantation of Bone Marrow
Other:	**NONE OF THESE APPLY**	

Past Surgical History: Please circle/check all that apply; if none apply, please circle/check *NONE* below the table

Abdominoperineal Resection	History of Liver Excision	Portosystemic Shunt Operation
Bilateral Replacement of Knee Joints	History of Percutaneous Transluminal Coronary Angioplasty	Prostatectomy
Biopsy of Breast	History of Tissue Graft Heart Valve Replacement	Prosthetic Arthroplasty of Bilateral Hips
Biopsy of Prostate	History of Total Cystectomy	Splenectomy
Coronary Artery Bypass Graft	History of Transurethral Prostatectomy	Surgical Biopsy of Skin
Entire Transplanted Kidney	Kidney Biopsy	Total Nephrectomy
Excision of Basal Cell Carcinoma	Lower Anterior Resection of Rectum	Total Orchidectomy
Excision of Melanoma	Lumpectomy of Left Breast	Total Replacement of Left Hip Joint
Excision of Squamous Cell Carcinoma	Lumpectomy of Right Breast	Total Replacement of Left Knee Joint
H/O: Colostomy	Mastectomy of Left Breast	Total Replacement of Right Hip Joint
H/O: Tubal Ligation	Mastectomy of Right Breast	Total Replacement of Right Knee Joint
History of Appendectomy	Mechanical Heart Valve Replacement	Transplantation of Heart
History of Bilateral Mastectomy	Oophorectomy	Transplantation of Liver
History of Cholecystectomy	Pancreatectomy	Other:
History of Colectomy	Percutaneous Extraction of Kidney Stone with Fragmentation Procedure	**NONE OF THESE APPLY**

Skin (and related) disease History: Please circle/check all that apply; if none apply, please circle/check *NONE* below the table

Acne	Dysplastic Nevus of Skin	Pruritus of Scalp
Actinic Keratosis	Eczema	Psoriasis
Asteatosis Cutis	H/O: Asthma	Squamous Cell Carcinoma
Basal Cell Carcinoma of Skin	H/O: Hay Fever	Sunburn of Second Degree
Contact Dermatitis Due to Poison Ivy	Malignant Melanoma	**Other:**
		NONE OF THESE APPLY

PATIENT NAME _____ **DATE OF BIRTH** _____

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For Patients Who Cannot Make Their Own Medical Decisions

If the patient has been determined to lack decision-making capacity, their legally designated Health Care Proxy (HCP) must be physically present at all office visits. Appointments will not be scheduled or confirmed unless the proxy agrees to attend. If the patient arrives without their proxy, the visit will be rescheduled. This policy is applied uniformly to all patients.

☐ **I understand and agree to this policy**

Signature: _____ Date: _____

Name (print): _____

ADDITIONAL DETAILS OF SKIN CANCER HISTORY: Please Circle

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(s)? _____

Medications: (**Please enter all current medications and dosage** - if none, please write **NONE**)
_____
_____
_____

Allergies: (**Please enter all allergies AND reactions to them** - if none, please write **NONE**)
_____
_____
_____

Family History of Cancer (Only first-degree relatives)
_____
_____
_____

Social History: Please Circle

Cigarette Smoking: Currently Smoke / Have smoked in the past / Never smoked / Former Smoker

Alcohol Use: None / less than 1 drink per day / 1-2 drinks per day / 3 or more drinks per day

Other: _____

Height_____ **Weight**_____

PATIENT NAME _____ **DATE OF BIRTH** _____

PATIENT SIGNATURE_____