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 / CANCELLATION FEES, AND CREDIT CARD POLICY

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 3 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 3 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 3 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 $50.00 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:___________________________

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____