Brandon Dermatology Patient Information

Name (Last, First, MI): _____

Male □ Female □ Marital status: _____ Date of Birth: ____ / ____ / ____ Age: _____
Race: White☐ Black/African American☐ Hispanic☐ Asian☐ Other_____
Preferred Language: English☐ Spanish☐
YES! Please email me Brandon Dermatology's specials, events and office updates☐

Social Security #: _____ - _____ - _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____Cell Phone: (____) _____ Work Phone: (____) _____

Driver's license #:_____State:_____

E-Mail Address:_____

Employer: _____ Occupation:_____

To notify in case of emergency: _____ Relationship: _____

Phone: (____) _____

Primary Care Physician:_____ Phone: (___) _____

Have any of your family members been seen here before? Y / N

If yes, Name:_____

Insurance Information:

□ Medicare and Secondary □ Medicare Replacement

□ Primary Insurance Company:_____

□ Secondary Insurance Company:_____

Please have your insurance card(s) ready so that we can scan into your chart.

If patient is not the policyholder, complete below:

Policy Holder Name (Last, First, MI):_____

Relation to Patient: _____ Phone: (_____)_____

Social Security #: _____ - _____ - _____ Male □ Female □ Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: (____) _____

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Patient/Parent/Authorized Representative Name: _____

Signature:_____ Today's Date:_____
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Brandon Dermatology Medical History

Patient: _____Date of Birth: ____/____/_____ Age: _____
(Last) (First) (M.I.) Male ☐ Female ☐

Personal History: (please check all appropriate boxes)

Arthritis/Joint Pain Yes ☐ No ☐
Artificial joint Yes ☐ No ☐
Cancer Yes ☐ No ☐
If yes, type: _____
Depression Yes ☐ No ☐
Multiple Sclerosis Yes ☐ No ☐
Thyroid Disease Yes ☐ No ☐
Kidney Disease Yes ☐ No ☐
Chron's/Colitis Yes ☐ No ☐
Liver Disease Yes ☐ No ☐
Gastric Ulcers Yes ☐ No ☐

Pacemaker Yes ☐ No ☐
Defibrillator Yes ☐ No ☐
Heart valve surgery Yes ☐ No ☐
High blood pressure Yes ☐ No ☐
Bleeding disorder Yes ☐ No ☐
Hepatitis Yes ☐ No ☐
AIDS/HIV Yes ☐ No ☐
Herpes/cold sores Yes ☐ No ☐
Tuberculosis Yes ☐ No ☐

Skin disease Yes ☐ No ☐
If yes, please list: _____
_____

Skin cancer Yes ☐ No ☐
Keloids Yes ☐ No ☐

Other_____
Medication prior to dental cleaning/procedures Yes ☐ No ☐

Family History:
Has anyone in your family had skin cancer? Yes ☐ No ☐ If yes, what type: _____

Medications: (please list ALL medicines including aspirin, birth control pills, vitamins/supplements, diet pills)
_____
_____
_____

Allergies to Medications: Yes ☐ No ☐ (please list)
_____
_____

Surgery: (list all) _____

Social History:
Do you smoke? Yes ☐ No ☐
Do you use snuff/smokeless tobacco? Yes ☐ No ☐

Occupation: _____Employer:_____

Women: (Please Complete)
First day of last menstrual cycle: _____
Pregnant: Yes ☐ No ☐
Breast-feeding: Yes ☐ No ☐

How did you hear about our practice: _____ Referred by: _____

I acknowledge that I have completed the above information to the best of my ability.

Patient Name: _____ Patient Signature_____ Date: _____

BRANDON DERMATOLOGY, PA

Statement of Financial Responsibility & Release of Information

1. Payment and Release of Information:
I hereby assume responsibility to pay to the costs of all services provided by Brandon Dermatology, P.A. and its physician(s) to the patient. My signature below signifies my understanding and willingness to comply with this policy. All payments are due at the time services are rendered unless prior arrangements have been made. There will be a $25 charge for all returned checks. I agree I may be charged a 1.5% interest rate per month and collection fees on any unpaid balances for which I am responsible. I understand that I have a right to have prescriptions filled at the pharmacy of my choosing.

Name of patient____________________ Signature of patient__________________________________

Name of parent/guardian______________________ Signature of parent/guardian__________________

Date_______________

2. Insurance:
I understand that Brandon Dermatology, P.A. and its physician(s) will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Brandon Dermatology, P.A. and its physician(s) of medical benefits, for the services provided. I understand that I am financially responsible for my health **insurance deductibles, coinsurance, and non-covered services.** I also understand that I am responsible for all necessary referrals if indicated by my insurance plan.

Name of patient____________________ Signature of patient________________________

Name of parent/guardian_________________ Signature of parent/guardian_______________________

Date_______________

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MEDICARE ONLY

Lifetime Authorization:
I Certify that the information given by me in applying for payment under Title XVIII and/or Title, of the Social Security Act is correct, and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediary carriers, any information needed for their or related Medicare claim. I hereby irrevocably assign payment to Brandon Dermatology and its physician(s) accepting assignment of all medical benefits applicable and otherwise payable to me. I also understand that Medicare will cover 80% of covered charges and I will be responsible for the other 20% unless covered by an additional insurance.

Signature as it appears on card____________________________________ Date_________________

If you have a supplemental policy we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release it to the MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on card_____________________________________ Date_________________

Patient Notice of Privacy
And Disclosure of Health Information

I understand that as a part of my healthcare, Brandon Dermatology and its physician(s) originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that as part of this organization's treatment, payment, and health care operations, it may become necessary to disclose my protected health information to another entity associated with my medical care. I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The complete Privacy Policy Notice of Brandon Dermatology and its physician(s) is available in the office for my perusal. I may also request my own copy if I desire.

I fully understand and accept the terms of this consent.

Patient Name (print)_____ Date_____

Patient Signature_____

Parent or Authorized representative (if applicable)_____

Please complete the following information:

Name of person(s) with whom we may discuss your medical information (i.e. wife/husband, child, etc)

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

May we leave a message about the following:

Upcoming scheduled appointments ☐ yes ☐ no

Normal laboratory/pathology results ☐ yes ☐ no