DiPreta Dermatology-Brunswick/Camden/Jesup/MS&SCC
Patient Annual Intake Form for New & Established

Patient Full Name:_____

Primary Mailing/Billing Address: _____

*City/State/Zip*_____

□ *Physical address (if different):*_____

Date of Birth:_____ Sex:____ Goes by/Nickname: _____

Marital Status: □ Single □ Married to _____ □ Divorced □ Other _____

Language(s): _____ Ethnicity: _____ Race: _____

Contact Phone Number(s): Home _____ Cell _____ Preferred Contact? Home Cell

ANY restrictions for contacting you? Y N Email Address: _____

Emergency Contact Name: _____
Phone(s) # _____ Relationship: _____ Is he/she on your HIPAA? Y N

Status: Student Retired Employed? Y N *If employed, Where*? _____

Primary Care Doctor/Provider: _____ in _____

Do you have insurance? __YES (***then must complete next section***) or __NO (*skip to bottom-self pay*)

INSURANCE: (you need to list name of plan and order plus we need copy of ins cards)

PRIMARY: _____ ID# _____ SS# _____
(*if not pt)* Insured Name:_____ Relationship: _____ Insured DOB: _____

SECONDARY:_____ ID# _____ SS# _____
(*if not pt)* Insured Name:_____ Relationship: _____ Insured DOB: _____

I have provided the most current address, contact phone numbers and insurance information along with current copies of all my insurance cards. I give permission for my insurance to be filed. I have reviewed and signed the HIPAA form and a financial policy. I am also aware that DiPreta Dermatology does not discriminate per Section 1557 and I can have access to interpretation services, if needed, at no additional fee.

My signature below signifies that I understand that I am responsible for updating this information at any future visits. If I fail to give correct or current info and can't be reached, it may delay communication of test results, appointment recalls or reminders and/or patient balance due after insurance processes charges.

SIGNATURE of PATIENT (guardian) _____

Relationship (if not pt): _____ Date: _____

MEDICAL HISTORY FORM – DiPRETA DERMATOLOGY

Pt Name:_____ Birthdate: ___/___/____ Age:____

Preferred Pharmacy:_____ Pharmacy Address_____ Do you use mail order? Y N

Reason for Your Visit Today: _____
Symptoms _____ Any Treatment Tried: _____

Med Hx Please mark IF applicable for you:	**Yes**	**No**		**Yes**	**No**
Cardiovascular ……	□	□	Gastrointestinal….	□	□
Bleeding Problems ……	□	□	**A**rthritis……	□	□
Diabetes? Type? ..…… _____	□	□	Hepatitis (A,B or C)……	□	□
High Blood Pressure……..	□	□	HIV (AIDS) ……	□	□
Pacemaker ……..	□	□	TB (Tuberculosis)…	□	□
Defibrillator?	□	□	STD? …….	□	□
Joint Replacement? _____	□	□	Stent? Where….	□	□

Personal History of Any Cancer? N Y _____ E***nter Estimated*** **Height:_____ Weight (lbs):_____**

MEDICATIONS: (prescription, over the counter, vitamins, and dosage) □ **See Attached List**

_____

Do you take blood thinners including herbal types? N Y ***If yes,*** please circle which ones you take:
Aspirin, Coumadin, Plavix, Warfarin, Vit E, Fish Oil, Feverfew, Saw Palmetto, Glucosamine, Ginger, Ginseng, Garlic,Xarelto
Other (list)_____ _____

ANY ALLERGIES? (medications, latex, tape, seasonal, anesthesia) _____

List all
SURGERIES:_____

SKIN CONDITIONS and HISTORY

Have you had skin cancer?	**NO** □	**YES**	**If Yes, Please list When? Where? By?**
Melanoma (Malignant Melanoma/MM)		□	_____
Basal Cell Carcinoma (BCC)		□	_____
Squamous Cell Carcinoma (SCC)		□	_____

Have you had abnormal/dysplastic moles? Nevus? **NO** □ **YES** □ _____

Have you had pre-cancerous or actinic keratosis? **NO** □ **YES** □ _____

List any other skin conditions you have (*examples: eczema, psoriasis, acne, rosacea, vitiligo, keloids/scars)*

Family History: Anyone in your family had **malignant melanoma**? Y N Who?
_____

Any Family history of skin cancer? Y N Who?

Social History:

	Mark Y or N	
Did you get a flu/influenza shot? …	____	If yes, when/where? _____
Did you get a pneumonia shot? ….	____	If yes, when? _____
Do you drink alcohol?.....	____	If yes, how much? Use Socially Use Daily
Do you smoke?.....	____	If yes, how much: Never/Former When did you start?____
Do you use sunscreen?.....	____	

FOR WOMEN ONLY*: Type of Birth Control (if applicable)_____* *Are you pregnant? Y N Are you breastfeeding? Y N*

Medical photographs: I am aware and consent for medical photographs to be made of me (or my child, or person for whom I am legal guardian**). I understand the information in my medical record is used for my continuum of care.**

Patient Signature: _____ Date: _____

Parent/Guardian Signature *(if minor <18):* _____ Relationship to Pt: _____

FINANCIAL POLICY

Payment & Collecting Balances and Collections

- We accept payment via cash, money order, checks, debit cards, credit cards (e.g. Amex, Visa, MC, Discover), or Care Credit.
- We accept payments via mail, in person, via phone, and/or online bill portal.
- If you do not have any insurance and are 'self-pay', then payment is due at time of service. If you do not have your insurance card or we cannot verify as active, you will be required to sign insurance waiver and asked for a prepayment up to $100.
- Co-payments and outstanding account balances are due at time of service, whether collected at check in or checkout. Any other balance due per insurance company will be due within 2 weeks from receipt of your statement. If your account is in arrears, you will be ask to "clear" your old balance prior to an upcoming appointment.
- Past due balances need to be paid prior to your next appointment Failure to comply and meet payment arrangement will trigger your account for review for clear/collections. clear balance is to be paid before your next visit.

Minors (Patients under 18 years old)

- All patient registration forms must be signed and guaranteed by a parent and/or legal guardian; if older than 18, patient signs.
- We are unable to know the financial responsibilities of separated and/or divorced parents. The adult accompanying the patient is responsible for the payment and can make arrangements with other parent at later time.
- Minor consent form is available for completion by parent/guardian for future visits.

Lab and Pathology Services

- **Lab and pathology services ordered by our office are billed separately to your insurance by those companies.**

*********NO SHOW FEE OF $50.00 WILL BE ASSESSED FOR ANY APPOINTMENT MISSED! KINDLY GIVE 48 HOURS NOTICE***********

I have read, acknowledged and accept to DiPreta Dermatology Financial Policy.

Patient Signature _____ Date _____ IF other than patient, Relationship to Pt _____

If the patient is a minor and you would like to authorize another designated adult, such as a grandparent or caregiver, to accompany the minor patient to their appointment, please list authorized adults below.

Parent/Guardian Authorization & Signature
Parent/Guardian Name (Printed): _____ Date: ____ / ____ / _____
Relationship to Minor: _____
Parent/Guardian Signature: _____

Name of Authorized Adult #1: _____ Name of Authorized Adult #2: _____
Relationship to Minor: _____ Relationship to Minor: _____

PATIENT HIPAA CONSENT FORM

PERMISSION FOR DISCLOSURES: ***(please pick one)***

____ **1**) Only disclose my treatment and payment/account info to me**.**

____ **2)** You can also disclose my treatment and payment/account info to the following people listed in addition to me:
a) _____ - Relationship = _____ Phone #
b) _____- Relationship = _____Phone #

To protect patient confidentiality, privacy, and the security of protected health information (PHI), our practice maintains a strict no-recording policy. This policy applies to all patients, family members, caregivers, and visitors.

Please note that it is your responsibility to notify our practice in writing if you no longer desire to have your protected health information disclosed to a family member or friend that you have previously authorized and/or not listed as an exception.

Patient Name (printed): _____ Date of Birth: _____

Signature _____ Relationship if not pt _____Date Updated: _____
(Patient or Guardian)
Staff Member Witness: _____