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Patient Information

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)	
Sex	Marital Status	Date of Birth		Social Security Number	
Patient's Address		City	State		Zip
Patient's Phone Number		Secondary Phone		Email Address	
Primary Care/ Referring Physician		Primary Care/ Ref. Physician Phone		Primary Care/ Ref. Physician Address	
Ethnicity				Preferred Language	

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance – Do NOT fill if you have a physical copy of your insurance card(s).

Primary Health Insurance

Insurance Company	Plan		
Plan Number	Group Number	Insured's Employer/ School	
Insured's Name (as it appears on the insurance card or ID)	Relation to Patient	Insured's Phone Number	
Insured's Address	City	State	Zip
Insured's Social Security Number	Insured's Birthday		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/ School	Insured's Social Security Number
Insured's Name (as it appears on the insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone		Relation to Patient
Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian *Date*

Last Name, First Name _____ Date of Birth ____/____/____

Pharmacy *(You may ALSO list your mail-order pharmacy – include Phone number)*

Pharmacy Name	Phone
Address (or Major cross-roads if not known)	Zip Code

Past Medical History *(Mark all that Apply)*

☐ **None**

☐ Anxiety disorder
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Benign prostatic hyperplasia (enlarged prostate)
☐ Cerebrovascular accident (stroke)
☐ Chronic obstructive lung disease
☐ Depressive disorder
☐ Diabetes mellitus
☐ Disease caused by 2019-nCoV
☐ Elevated blood pressure (hypertension)
☐ End-stage renal disease
☐ Epilepsy (seizures)
☐ Gastroesophageal reflux disease
☐ Hearing Loss
☐ Hepatitis B
☐ Hepatitis C
☐ HIV/AIDS
☐ High Cholesterol
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Malignant lymphoma
☐ Malignant tumor of lung (lung cancer)
☐ Malignant tumor of breast (breast cancer)
☐ Malignant tumor of colon (colon cancer)
☐ Malignant tumor of prostate (prostate cancer)
☐ Radiation Therapy of bone marrow
☐ Transplantation of bone marrow

☐ Autoimmune disease (Specify) _____

☐ Other (Specify) _____

Past Surgical History *(Mark all that Apply)*

☐ **None**

☐ Biopsy of breast
☐ Biopsy of prostate
☐ Coronary artery bypass graft
☐ Entire transplanted kidney
☐ Excision of basal cell carcinoma
☐ Excision of melanoma
☐ Excision of squamous cell carcinoma
☐ H/O: tubal ligation
☐ History of appendectomy (appendix removal)
☐ History of cholecystectomy (gallbladder removal)
☐ History of colectomy (colon removal)
☐ History of liver excision (biopsy)
☐ History of total cystectomy (bladder removal)
☐ History of transurethral prostatectomy (prostate)
☐ Hysterectomy
☐ Kidney biopsy
☐ Lumpectomy of left breast
☐ Lumpectomy of right breast
☐ Mastectomy of left breast
☐ Mastectomy of right breast
☐ Mechanical heart valve replacement
☐ Oophorectomy (ovaries removed)
☐ Prosthetic arthroplasty of bilateral hips
☐ Splenectomy
☐ Surgical biopsy of skin
☐ Total nephrectomy (kidneys removed)
☐ Total orchidectomy (testicle removal)
☐ Total replacement of hip (Circle: Left, Right, Both)
☐ Total replacement of knee (Circle: Left, Right, Both)
☐ Transplantation of heart
☐ Transplantation of liver

☐ Other (Specify) _____

Pediatric History (for Patients under 12)

Full Term Infant: ☐ Yes ☐ No
If no, how many **weeks** were you pregnant at delivery (**gestational age**)? _____

Birth Weight (lbs **or** oz): _____ Delivery: ☐ Vaginal ☐ C-Section

Prenatal Care ☐ Yes ☐ No
Vaccines up to date? ☐ Yes ☐ No

Any Maternal Illness During Pregnancy? _____

Skin Disease History *(Mark all that Apply)*

☐ **None**

☐ Acne
☐ Actinic Keratosis
☐ Asteatosis cutis (dry skin)
☐ Basal Cell carcinoma of skin
☐ Contact dermatitis
☐ Dysplastic nevus of skin (moles atypical)
☐ Eczema
☐ H/O: asthma
☐ H/O: hay fever
☐ Malignant melanoma
☐ Pruritus of scalp (itchy scalp)
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ Sunburn of second degree

☐ Other (Specify) _____

Family History of MELANOMA ☐ **Yes** ☐ **No**

If YES to Melanoma, which relative(s)? _____

If YES to Melanoma, any other family history (breast, ovarian, pancreatic or prostate cancers)?

_____

Medications ***(Enter all current medications and strengths)***

☐ **None Patient Height:** _____ **Patient Weight:** _____

Medication:	Medication:	Medication:
Medication:	Medication:	Medication:
Medication:	Medication:	Medication:

Medication:	Medication:	Medication:

Drug Allergies: *(Please list your drug allergies and the reaction caused)*

☐ **No Known Drug Allergies** ☐ Latex

Drug Name:	*Reaction (circle):* anaphylaxis, angioedema, diarrhea, fatigue, GI upset, hives, liver toxicity, or rash
Drug Name:	*Reaction (circle):* anaphylaxis, angioedema, diarrhea, fatigue, GI upset, hives, liver toxicity, or rash
Drug Name:	*Reaction (circle):* anaphylaxis, angioedema, diarrhea, fatigue, GI upset, hives, liver toxicity, or rash

Social History: *(Mark all that apply)*

Cigarette Smoking (MUST answer)
☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never smoker

Alcohol (EtOH) Use:
☐ None
☐ Less than 1 Drink a day
☐ 1-2 Drinks per day
☐ 3 or more Drinks per day

How many times in the past year have you had 4 or more drinks in a day?
☐ Less than Twice per Year
☐ More than Twice per Year

Illicit Drug Use:
☐ Drug Use
☐ IV Drug Use
☐ IV Drug Use within past 12 months

***Sexual History*:**
☐ Not Sexually Active
☐ Sexually Active w/ one partner
☐ Sexually Active w/ more than one partner
☐ Sexually Active w/ Same-Sex partner

Safety:
☐ I feel safe at home
☐ I do not feel safe at home

Other _____

Review of Systems: *Are you currently experiencing any of the following? (Please check yes or no)*

Headaches	☐ Yes	☐No
Dryness	☐ Yes	☐No
Blurred Vision	☐ Yes	☐No
Moodiness/ Anxiety	☐ Yes	☐No
Fever/ Having signs of Illness	☐ Yes	☐No
Problems Healing/ Scars	☐ Yes	☐No

Other Symptoms _____

Alerts: *Do you currently have any of the following? (Please check yes or no)*

Premedication prior to procedures	☐ Yes	☐No
Pacemaker	☐ Yes	☐No
Artificial Joints within the past 2 years	☐ Yes	☐No
Are you pregnant	☐ Yes	☐No

If yes, due date: _____

Other Alerts to be known _____

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Financial Policy

The following financial policy has been developed to help you better understand your obligations and avoid common problems surrounding insurance reimbursement.

Please be aware that insurance companies differ greatly in terms of which services are covered and what portion of a covered service they will reimburse. Even within a single insurer, multiple plans may exist depending on the contract terms negotiated by your employer/group. Your insurance policy is a contract between you, your employer, and the insurance company. All charges are your responsibility, whether your insurance company pays or not.

Regulations do not permit a physician to set fees specific to individual insurance companies.

1. If you are an enrollee of a managed care plan with which we contract, you are required to pay applicable co-payments each time you are seen.
2. In addition to the co-payment, some plans have an annual deductible. You are required to pay this at the time of service. Also, you are required to pay any account balances at the time of service.
3. If we participate with your insurance, we will collect any applicable payment due at the time of service and send a claim for your services to your insurance company. Once your insurance has returned an Explanation of Benefits, you may then be billed for any non-covered services, deductibles or coinsurance that you may be responsible for as outlined in your insurance plan. Please do not hesitate to contact our Billing Department at 480 832-2213 if you have any questions regarding a bill received from Dermatology Solutions.
4. Covered services vary amongst individual insurance companies. Most insurance companies will not cover cosmetic procedures. Please take the time to review and notify us of your insurance company's policies. In the event of non-covered and cosmetic procedures, payment in full will be required at the time of service.
5. Some insurance companies require that lab work be sent to a specific laboratory. It is your responsibility to know which lab(s) your insurance company contracts with and to inform the draw station.
6. If your insurance requires a referral from your Primary Care Physician, it is your responsibility to obtain the referral prior to being seen at our office.
7. An additional charge of 35% will be added to any accounts that are delinquent and placed in collections. You will be responsible for all attorney fees and court costs associated with these collections. The delinquent amount will be placed with a Credit Reporting Agency and may affect your credit rating.
8. Please notify us as soon as possible if you need to cancel or reschedule an appointment so that other patients can be seen. Cancellations must be received 24 hours prior to your appointment; otherwise, your account will incur a charge of $25.00 for medical appointments. Uncancelled surgical and cosmetic appointments will incur a charge of $50. Returned checks will also incur a charge of $25.00.

Although it is your responsibility to understand your insurance plan benefits, our staff is dedicated to working with you and your insurance carrier to ensure appropriate reimbursement for your medical bills. Please contact our billing department at 480 832-2213 with questions.

I have read and understand the above Financial Policy and I agree to abide by its terms.

Signature of Patient / Responsible Party _____ Date _____

Printed Patient Name _____