

Dermatology Medical History

Patient: _____ Date: ____ / ____ / ____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____

Are you allergic to Latex? YES NO

Are you allergic to Lidocaine? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
			Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

- Have you ever had skin cancer? YES NO If yes, _____
- Has anyone in your family had skin cancer? YES NO If yes, _____
- Do you have a history of any specific skin diseases? YES NO If yes, _____
- Do you have problems with healing YES NO
- Do you develop keloids (scars) after surgery YES NO
- Do you bleed easily? YES NO
- Do you develop skin rashes in reaction to Medications Food Environment? _____

Social History:

- Do you drink alcohol? YES NO If YES _____ drinks per day
- Do you use IV drugs? YES NO If YES, what? _____ How often? _____
- Do you smoke? YES NO If YES, how much: _____
- Have you had or have you been exposed to HIV (AIDS)? YES NO

Please answer the following questions:

(Women) Are you pregnant? YES NO First Day of Last Menstrual Cycle: ____ / ____ / ____

What is your occupation? _____ Hobbies? _____

Completed by: Patient _____
 Medical Assistant _____
Initials _____

Signed by Patient _____ Date ____ / ____ / ____

Reviewed by _____ Date ____ / ____ / ____

Patient Information

Patient's Full Name _____ Sex _____

Street Address _____

City, State, Zip _____

Phone (home) _____ (work/cell) _____

Employer _____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Referred by _____

Responsible Party _____ Address _____

Insurance Information – Please present your insurance card

Primary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birth date _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone _____

Secondary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birth date _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone _____

I understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all of the information on BOTH sides of this sheet and have completed the above information. I certify this information is true and correct to the best of my knowledge. Additionally, I hereby authorize the release of any protected health information necessary to process claims for medical services performed on me. I also request that payment be sent to the provider of services Steven K. Grekin, D.O., P.C., Don Collier, D.O., P.C., Wendy Lambert, D.O., P.C., Michelle K. Bruner, D.O., Michael W. Whitworth, D.O., or Jennifer Meitzner, NP.

Signature _____ Date: _____

Updated _____ Date: _____

Dermatology Warren

About Financial Arrangements

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered unless we are aware you have insurance coverage for this particular visit. It is the patient/subscriber's responsibility to submit claims covered under any Master/Major medical policy, unless prior arrangements have been made with the office staff. Returned checks and balances older than 30 days may be subject to additional collection fees.

We participate with various insurance plans, accepting assignment of benefits. Please check with your insurance company to verify that the doctor you are seeing is a participating provider. Copayments, coinsurances, and deductibles remain your responsibility. It is the responsibility of the patient/subscriber to obtain any necessary referral forms or authorization numbers. If you fail to obtain these necessary forms/numbers you will be held responsible for your balance. Please be advised that our office takes, CASH, CHECKS, VISA, MONEY ORDER, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.

We are happy to process other insurance plans. You must realize however, that:

- 1) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.**
- 2) Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies which pay a percentage (such as 50% or 80%) of "U.C.R.". U.C.R. is defined as "Usual, Customary, and Reasonable" by most companies. This is a "schedule of fees" which bears no relationship to the current standard and cost of care in the area.**
- 3) Not all services are a covered benefit on all contracts. Some insurance companies arbitrarily select certain services they will not cover.**

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Should problems arise affecting your timely payment of this account, we encourage you to contact the billing office promptly for assistance in working this out.

If you have any questions regarding the above information, please do not hesitate to ask us. We are here to assist you.