Medical History Form

Last Name: ______________________________ First Name: ___________________________ MI:______

Date of Birth: (MM/DD/YY) ________________ Today's Date: __________________________________

Preferred Pharmacy:________________________ Cross Streets:_________________________________

Reason for today's visit?____

Past Medical History:

Have you been previously diagnosed with any of the following?

Anxiety
Arthritis
Asthma
Atrial Fibrillation
(Irregular Heartbeat)
Benign Prostatic
Hyperplasia (BHP)
Bone Marrow
Transplant
Breast Cancer
Colon Cancer

Chronic Obstructive
Pulmonary Disease
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Failure
Gastro Esophageal
Reflux Disease
Hearing Loss
Hepatitis
Hypertension

HIV/Aids
Hypercholesterolemia
Hyper/Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

List any other past or present diseases or conditions: ____

List any surgical procedures you have had in the last 24 months: _________________________________
____

Skin Disease History:

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema

Flaking or Itchy Scalp
Melanoma
Precancerous Moles
Psoriasis
Squamous cell skin cancer
None

Other: ____

Do you wear sunscreen? Yes No If so, 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? ____

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

________________________	______________________	_________________________
________________________	______________________	_________________________
________________________	______________________	_________________________

Are you allergic to any medications? Yes No If yes, list below:

________________________ ______________________ _________________________

Social History:

Do you use IV drugs? Yes No If yes what? ___________ How often?________
Do you drink alcohol? Yes No If yes how many per day? __________________
Do you currently smoke? Yes No Former Never

Do you develop Keloid (raised) scars after surgery?	Yes	No	Not Sure
Do you have problems with healing?	Yes	No	Not Sure
Do you bleed easily?	Yes	No	Not Sure

Have you been previously diagnosed with any of the following?

Allergy to adhesive	Blood thinners
Allergy to lidocaine	Defibrillator
Allergy to topical antibiotic ointments	MRSA
Pacemaker	Premedication prior to procedures
Artificial heart valve	Rapid heartbeat with epinephrine
Artificial joints	None

Have you had a reaction to local anesthesia (Novocain) at a dermatology or dental visit?
Yes No

Women:

Could you be pregnant or are you trying to become pregnant soon? Yes No
Are you currently breastfeeding? Yes No
Do you get yeast infections with antibiotic use? Yes No

What is your occupation? ____
What are your hobbies? ____

Are you interested in speaking with our aesthetician about your skin care needs? Yes No

New Patient Information

PATIENT INFORMATION:

Last Name: ______________________________First Name: _____________________________MI: _________

Date of Birth (MM/DD/YY): _________________ Today's Date: ____________________Sex: M F

Address: _______________________________ City, State, Zip: _______________________________________

Home Phone: _______________________Cell: _______________________ Work: _______________________

What is the first/best number you would like us to try to reach you? Home Cell Work

Email Address: ________________________________ Employer Name: ________________________________

Ethnicity/Race: ________________________________ Preferred Language: _____________________________

How would you like to be notified for your appointment confirmations?

Text Email Phone Call Please indicate which phone: Home Cell Work

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE):

Last Name: ____________________________First Name: ________________________ DOB: ______________

Address: _______________________________ City, State, Zip: _______________________________________

Home Phone: _______________________Cell: _______________________ Work: _______________________

IN CASE OF EMERGENCY: (PLEASE NOTIFY)

Name: __________________________Phone: _______________Relationship to Patient: __________________

May we discuss your medical information with this person? Yes No

PATIENT INSURANCE INFORMATION:

Primary Insurance

Insurance Name: ____________________________

Subscriber ID: ______________________________

Group ID: __________________________________

Policy Holder Name: ________________________

Relationship to Patient: ____________________

Policy Holder's Date of Birth: ________________

Policy Holder's SS#: ________________________

Secondary Insurance

Insurance Name: ____________________________

Subscriber ID: ______________________________

Group ID: __________________________________

Policy Holder Name: ________________________

Relationship to Patient: ____________________

Policy Holder's Date of Birth: ________________

Policy Holder's SS#: ________________________

Name of Primary Care Physician: ____

Address: _______________________________ City, State, Zip: _______________________________________

Office Phone #:__________________________ Office Fax #: ____

Name of Referring Physician (if different from above):____

Address: _______________________________ City, State, Zip: _______________________________________

Office Phone #:__________________________ Office Fax #: ____

Name of any other Physician you want us to share your visit notes with: _____________________________

Address: _______________________________ City, State, Zip: _______________________________________

Office Phone #:__________________________ Office Fax #: ____

I hereby authorize Mountaintop Dermatology to fax or mail information pertaining to my care to my primary care, referred, or referring healthcare provider. ______ Initial

How did you hear about Mountaintop Dermatology?

Internet search   Dex phonebook   Tri-Lakes phonebook   Insurance provider website
Building Sign   Referral from patient   Other: ____________________________________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have, or have been given the opportunity, to read in full and obtain my own copy of the **Notice of Privacy Practices** from Mountaintop Dermatology. *Required by government statute. ______ Initial

NOTICE OF FINANCIAL POLICY

I acknowledge that I have, or have been given the opportunity, to read in full and obtain my own copy of the **Financial Policy Statement** from Mountaintop Dermatology and I agree that I am financially responsible for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my appointment. ______ Initial

PAYMENT AUTHORIZATION

I authorize payment of all insurance benefits, if any, to be made directly to Mountaintop Dermatology for all services rendered. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. ______ Initial

LATE CANCELLATION AND NO SHOW POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment, however, when a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. As of June 1, 2014 there will be a **fee of $25.00** assessed if we do not receive notice of cancellation at least 24 hours in advance of your scheduled appointment. ______ Initial

ACKNOWLEDGEMENT:

By signing this authorization, I acknowledge the accuracy of all information provided.

____   ___________________

Patient Signature or Legal Guardian, if a minor*   **Date**

Consent for Treatment & Financial Policy Statement

CONSENT FOR TREATMENT:
By signing this form, I authorize Mountaintop Dermatology and its personnel to provide ongoing medical care, treatment and procedures (skin biopsies, routine surgical procedures etc.) as ordered by the physician and/or other health care providers. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

INSURANCE PARTICIPATION:
As a service to our patients, we will file claims to the companies we are contracted with for the services provided. It is the patient's responsibility to ensure that the physician he/she is seeing is listed with their insurance company as a participating provider. Any patient treated by a non-participating physician will be responsible for any deductibles, co-insurance, uncovered services, etc., imposed by their insurance company.

PATIENT RESPONSIBILITY:

- Verify with your insurance carrier that the services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits. Any disputes about payment must be resolved between you and your insurance company.
- Obtain any authorizations or referrals required by your insurance carrier.
- Pay our office for any co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB).
- All patients without insurance must pay in full at the time services are rendered. *Please ask about our discounted rate for self-pay patients.

RELEASE OF ASSIGNMENT:
I hereby give authorization for payment of all insurance benefits to be made directly to Mountaintop Dermatology for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits.

DENIED CLAIMS:
Our billing agent will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions or any other matter, which causes the claim to be denied. Should your claim be denied for any of these reasons or any other reasons not listed here, the claim will become the responsibility of the patient and full payment will be expected immediately.

LABORATORY CHARGES:
Please note that the services provided to you may require outside lab work. We will forward your laboratory tests to a participating lab company whenever possible. **You will receive a separate bill for any services provided by the laboratory.** If you would like an estimate of lab charges prior to service please contact CU Dermpath directly at 303-344-1290.

PAYMENT OPTIONS:
For your convenience we offer a variety of payment options. We accept Visa, Master Card, and Discover Card, Personal Checks, Cashier/Bank Checks and Cash. All returned checks will be assessed a $30.00 returned check fee in addition to the original charge.

ACCOUNT BALANCES/COLLECTIONS:
I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default (unpaid balance 90 days from date of treatment) I understand my account may be assessed an additional $25.00 transfer fee and your account will be forwarded to an outside collection agency. I agree to pay all costs of collection including but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs.

LATE CANCELLATION AND NO SHOW POLICY:
We understand that unplanned issues can come up and you may need to cancel an appointment, however, when a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Circumstances have caused us to enforce a policy of charging for no show appointments, and those appointments not cancelled within 24 hours. As of June 1, 2014 there will be a **fee of $25.00** assessed if we do not receive notice of cancellation at least 24 hours in advance of your scheduled appointment. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

ACKNOWLEDGEMENT:
I acknowledge that I have read and understand Mountaintop Dermatology's Consent for Treatment & Financial Policy Statement and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Mountaintop Dermatology at any time.

____ ______________

Patient Signature or Legal Guardian, if a minor* **Date**