DERMATOLOGY & SURGERY ASSOCIATES CENTER

How did you hear about us?

	Doctor Referral
	Social Media
	Online Ad
	Newspaper
	Television Ad or Program
	Word of Mouth
	Other:

Dermatology Associates and Surgery Center
INTAKE AND HISTORY FORM

Today's Date:	Primary Physician:	
If under the age of 18, name of the responsible party:	Date of Birth:	Phone No.:

PATIENT INFORMATION

Patient's name:	Date of Birth:	Gender: (M) OR (F)
Mailing Address:		
City/State/ Zip Code:		
Social Security no.:	Home phone no.:	Cell phone no.:
Email Address:		
Emergency Contact:		Date of Birth:
Preferred Language:	Race:	Ethnic Group:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance that is owed and may be held liable for that which is not paid.

X _____ X _____

Patient/Guardian signature Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABLILITY ACT OF 1996 (HIPAA)

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of protected information pertaining to our patients. The purpose of the policy is to ensure that our practice and physicians and staff have the necessary medical information to provide the highest quality medical care possible while protecting the confidentiality of the information of our patients to the highest degree possible. I have been given a copy of the Dermatology Associates & Surgery Center's Privacy Notice and by signing below acknowledge such.

X _____ X _____

Patient/Guardian signature Date

AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION

I give the physicians and staff of Beckley Dermatology, Inc. my permission to speak with the following person(s) listed below about my medical condition or any other information necessary for treatment or payment operations..

Name:	Name:
Name:	Name:

SKIN DISEASE HISTORY

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itching Scalp
- ☐ Hay Fever/ Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None
- ☐ Other: _____

Do you wear Sunscreen?

☐Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon?

☐Yes ☐ No

Do you have a family history of Melanoma?

☐Yes ☐ No

Is yes, which relative? _____

_____

_____

SOCIAL HISTORY

Do you have any advanced directives?

- ☐ Do Not Resuscitate _____
- ☐ Medical Power of Attorney: Name: _____

  Phone No.: _____
- ☐ Living Will _____

Smoking Status (please choose)

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoked
  - Start Smoking: (mm/dd/yyyy)_____
  - Quit Smoking: (mm/dd/yyyy)_____
  - Number of Packs Per Day:_____
  - Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Have you had the following Vaccines?

- ☐ Flu (date)_____
- ☐ PCV 13

  (Pneumococcal Conjugate Vaccine)

  (date)_____
- ☐ PPSV23

  (Pneumococcal Polysaccharide Vaccine)

  (date)_____
- ☐ Shingles (date)_____

MEDICATION (MAY PROVIDE LIST OR ADDITION PAGES IF NEEDED)

Medication	Dose	Route	Frequency

PREFERRED PHARMACY

Name: _____ Phone: _____

Address: _____ Zip Code: _____

ALLERGIES (PLEASE LIST BELOW)

_____

_____

Date Completed: _____

Self Pay/Private Pay Financial Policy

Patient Name: _____ Chart #: _____

Date of Birth: _____ Initial Date of Service: _____

Full Address: _____

Home Phone: _____ Cell Phone: _____

By signing the below I agree that:

- At this time I do not have health insurance coverage. I understand that I am responsible for all charges for office visits, procedures and lab specimens that are obtained and performed at Dermatology Associates & Surgery Center.
- If at any time I have a change in insurance coverage and choose to have insurance submitted, it is my responsibility to notify Dermatology Associates & Surgery Center of these changes.
- If I have any questions regarding my account balance I will contact the billing office at 1-800-835-1945 or 1-540-504-0326.
- I understand that a payment of $100.00 must be paid in advance if I am a new patient, $50.00 if I am here for a return visit.
- Before any surgical procedures are scheduled, the front office will discuss the cost and payment arrangements will be made.
- A prompt pay discount of 30% will be given if payment made within 10 days of first statement being sent out.

Patient signature: _____ Date: _____

Representative from Beckley Dermatology: _____