

GOLDMAN DERMATOLOGY, PLLC
PATIENT INFORMATION FORM

Patient Name: _____

Social Security #: _____

Address: _____ Apt: _____

Date of Birth: ____/____/____ Gender: ()M ()F

City: _____ State: _____ Zip: _____

Marital Status: () S () M () D () W

Employer: _____

Phone #'s: (H): (____) _____

Name of Parent or Guardian (if minor): _____

(W):(____) _____

Referring Physician: _____

(C):(____) _____

or Friend: _____

E-mail: _____

Referring Physician Phone #: _____

Permission to contact by E-mail: () yes () no

Emergency Contact Name: _____

For Medicare Patient's:

Primary Care Physician: _____

Relationship to Patient: _____

Phone # & Address: _____

Emergency Contact #: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Co: _____

Insurance Co: _____

Policy #: _____

Policy #: _____

Group #: _____

Group #: _____

Insurance Phone #: _____

Insurance Phone #: _____

If insurance is other than patient's:

If insurance is other than patient's:

Insured Name: _____

Insured Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

Insured's Date of Birth: _____

Insured's Date of Birth: _____

Insured's SS#: _____

Insured's SS#: _____

Name of Company: _____

Name of Company: _____

Can we leave messages about lab or biopsy results on your phone? ___ Yes ___ No

If you would like the doctor to see you alone, please let the medical assistant in the room know.

I hereby authorize *GOLDMAN DERMATOLOGY, PLLC* to furnish information concerning my illness and treatment to my insurance carriers.

I authorize payment of medical benefits to *GOLDMAN DERMATOLOGY, PLLC*.

I understand that I am responsible for any part of the charges that are not covered by medical coverage.

I HAVE RECEIVED A COPY OF THE PATIENT PRIVACY NOTICE.

Signed: _____

Date: _____

(Signature of Patient or Parent /Guardian if patient is a minor)

DERMATOLOGY MEDICAL HISTORY

Patient Name: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? Yes No

1. _____ 2. _____
3. _____ 4. _____

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

1. _____ 2. _____
3. _____ 4. _____

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

Lungs:

Bronchitis Yes No
Emphysema Yes No
Asthma Yes No
Chronic Cough Yes No
Morning Cough Yes No
Wheezing Yes No

Cardiovascular:

High Blood Pressure Yes No
Chest Pain Yes No
Heart Attack Yes No
Irregular Heartbeat Yes No
Phlebitis Yes No
Inflammation of veins Yes No
Blood Clots Yes No
Pacemaker Yes No
Fainting Yes No

Other Systemic:

Diabetes Yes No
Excessive thirst/hunger Yes No
Thyroid Yes No
Kidney Yes No
Bladder Yes No
Frequency/burning Yes No

Gastrointestinal:

Stomach absorptive disorder Yes No
Nausea, vomiting, diarrhea
when taking antibiotics Yes No
Yeast infection when
taking antibiotics Yes No
Arthritis/Joint Deformity Yes No
Arthralgia Yes No
Limited motion Yes No
Artificial joint Yes No
Convulsions, Seizures Yes No

Skin:

When you are exposed to the sun do you: Tan only Tan and burn Burn only
Have you ever had skin cancer? Yes No
Has anyone in your immediate family had skin cancer? Yes No If yes, what type? _____
Do you have a history of any specific skin diseases? Yes No

If yes, please list: _____

Do you develop skin rashes in reaction to Medications Food Environment?

List any other diseases or conditions: _____

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

Please answer the following questions:

Have you had or have you been exposed to HIV/AIDS Yes No
Do you bleed easily? Yes No
(Women) Are you pregnant? Yes No

____ Please check here if you would like to learn more about our skin care products or if you would like a consultation with our esthetician. _____ Not Interested

Please indicate whether you are interested in learning more about the following: (Please Check)

BOTOX JUVEDERM RESTYLANE HAIR REMOVAL MICRODERMABRASION
 CHEMICAL PEELS LASER FOR BROKEN VEINS LASER FOR ACNE LASER FOR BROWN
SPOTS SCLEROTHERAPY CELLULITE ACNE SCARS WRINKLES

All procedures are done in the office. If any of these are of interest to you, please let us know and we can discuss them with you as well as provide information.

Completed by: Patient
 Medical Assistant

Patient Signature Date

Physician Signature Date

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

- **COPAYMENTS-** By contract we **MUST** collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit.
- **NON-COPAY PLANS-** If your plan does not require a copay and we participate , we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on the explanation of benefits.
- **REFERRALS-** If your plan requires a referral from your primary care physician it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER.** It is your responsibility to provide us with the referral as soon as possible. Referrals do have expiration dates. Please check before scheduling your follow-up visits or else you are responsible for the visit.
- **NON PLAN PATIENTS-** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly.
- **MEDICARE-** We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance , which can be billed to a secondary insurance if you have one.

Our office does have a financial policy for no-show patients and same day cancellations. We require 24 hours notice prior to the appointment. We reserve the right to charge \$75 for continued no shows and same day cancellations. All patient financial responsibilities are to be paid at the time of service. There is a service fee of \$50 for returned checks. In the event that collection efforts have to be made to an outside collections agency or to an attorney, you will be responsible for all costs incurred to collect the debt.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA OR AMEX.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____