PLATINUM DERMATOLOGY NETWORK™ New Patient Information & History Form

PATIENT INFORMATION:

Name: _____ Home Phone: (_____) _____ - _____

Address: _____ Cell: (_____) _____ - _____

City: _____ State: _____ Zip: _____ E-mail: _____@_____

May we contact you via text / email you for appointment reminders and follow-up? YES NO

May we email you for promotions, discounts, events and other exciting activities? YES NO

DOB: ____/____/_____ Age: ____ Sex: M / F Married? Y / N Spouse Name: _____

SSN: _____/_____/_____ Driver's License #: _____

Occupation: _____ Work #:(____) _____-_____

Employer: _____ City: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE:

Name of Parent/Guardian: _____ Phone #: (____) _____-_____

Employer: _____ Work #: (____) _____-_____

NEXT OF KIN/FRIEND NOT LIVING WITH YOU:

Name: _____ Relationship: _____ Phone #: (____) _____-_____

WERE YOU REFERRED BY A PHYSICIAN?

Physician Name: _____ Tel #: (_____) _____-_____

Address: _____ City: _____ State: _____

IF NOT, HOW DID YOU HEAR ABOUT US?

☐ Friend/Family ☐ Internet Ad ☐ Insurance Company ☐ Google ☐ Magazine

☐ Article ☐ Social Media ☐ Event ☐ Our Website ☐ Other:

INSURANCE/PAYMENT INFORMATION:

Insured Person's Name: _____ Relationship: _____

DOB: _____/_____/_____ Insurance Company _____

Group #: _____ Member #: _____

We aim to offer exceptional, thorough care of each patient, while also remaining respectful of other patients' time and needs. This allows us to successfully address up to three (3) medical issues per visit. Additional medical conditions need to be addressed at a future visit. Thank you for your understanding and for choosing us. We are honored to care for you!

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Electronic prescribing systems can help reduce errors and allow your dermatologist to check medications prescribed by other physicians and healthcare providers. I agree to allow my dermatologist to perform this check if found to be medically necessary or useful.

Current Skin Condition of Concern: _____
Please list any specific cosmetic concerns: _____

MEDICAL HISTORY:

☐ Cataracts ☐ Cancer ☐ Osteoarthritis ☐Osteoporosis ☐ Glaucoma ☐ Diabetes

☐ Hay Fever ☐ Asthma ☐ HIV/AIDS ☐ Kidney Disease ☐ Thyroid Disease ☐ Epilepsy

☐ Heart Disease ☐ Liver Disease ☐ Blood Pressure ☐ Nail Disorder ☐Acid Reflux

☐ Cholesterol ☐ Pacemaker/defibrillator

☐ Currently Pregnant/Due Date: _____/_____/_____ ☐ Currently Breastfeeding Y / N

☐ Operations: _____

☐ Transplants (list organ): _____

☐ Current Medication: _____

_____

Circle one: Smoke: Yes / No Drink Alcohol: Yes / No If yes, how many? _____

Used a tanning bed in the past year: Y / N

☐ Previous Skin Cancer (circle)? BCC Location: _____ Date_____

SCC Location: _____ Date _____

Melanoma Location: _____ Date _____

BCC= basal cell carcinoma; SCC= squamous cell carcinoma

☐ Family History of Skin Cancer? BCC SCC Melanoma Unknown Type

☐ Family History of Skin Problems? _____

Heritage: Black / Asian / Caucasian / Latino / Other: _____

Medication Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

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NOTICE REGARDING PAYMENTS/INSURANCE CLAIMS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of visit. If you cannot provide the information, we will be unable to file your insurance and payment in full will be required on the day the service is provided. The exact payment amount cannot be determined with complete accuracy until the claim is submitted to your insurance company.

Your payment will be based on your individual health plan, deductible and/or coinsurance. Procedures and evaluations which are excluded from coverage, such as cosmetic procedures and evaluations, benign mole removal, and skin tag removal, will be your responsibility, based on your plan's determination of medical necessity. Your office co-pay is due at the time of the visit and, in most cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance usually apply. For all other patients, payment in full is required at the time of service.

Standard office policy requires that you must present your drivers' license (or ID), insurance card (if applicable) and a credit/debit card for verification and for our records.

I have read the above information and understand that I am responsible for payment of services I receive.

Patient/Guardian Signature: _____ Date: _____