Patient Name: ____Todays Date: __________________

***General Patient Information**

Patient Name____

Age ______ Date of Birth ______/_______/________ SS# _______-_____-________ Sex: M F

Marital Status ____________________________ Email ____

Phone: Home (_________) _________-_________ Cell (_________) _____________-___________

Mailing- Address, City, State & Zip

____

____

***PARENT OR RESPONSIBLE PARTY** (if different from patient)

Name of Insured ____Relationship to Patient________________

Date of Birth ________/_________/__________ SS# ________-______-_________ Sex: M F

Marital Status ____________________________ Email ____

Phone: Home (_________) _________-_________ Cell (_________) _____________-___________

Billing - Address, City, State & Zip

____

____

***INSURANCE INFORMATION (Please present insurance card at time of check in).**

Primary Insurance Name ____

Policy Holder's Name ____

SS# ________-________-__________ Date of Birth ________/________/_____________

Group # ___________________________ Contract # ____

Employer Name: ____ Employer Phone #: ______/______/_______

Relationship of patient to the Insured ____

**Do you have secondary Insurance? ____

***In case of Emergency, who should be notified (other than those already listed above)?**

Name: ____ Phone: _______/________/_________

Relationship: ____

*All of the above is correct to the best of my knowledge, and I agree to notify this office in a timely manner of any changes.

____ Date _________/__________/20________

Patient or Responsible Party Signature

PATIENT NAME____TODAYS DATE_____________________

What is the main reason for your visit today? ____

____

***Past Medical History: (please check all that apply) *must check "None" if none apply**

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Depression
- Diabetes
- Stroke
- Thyroid Problems

-Hyperthyroidism

-Hypothyroidism

- GERD (Acid reflux)
- Bone Marrow Transplantation
- Hearing Loss
- Leukemia
- Organ Transplant
- BPH (Prostate Enlargement)
- Lung Cancer
- Breast Cancer
- High Blood Pressure
- Lymphoma
- Colon Cancer
- Prostate Cancer
- High Cholesterol
- Seizures
- Radiation Treatment
- End Stage Renal Disease
- Coronary Artery
- Disease COPD
- HIV/AIDS
- Hepatitis
- Shingles
- Shingles vaccine?
- OTHER:

____

____

____

____

- **NONE**

***Past Surgeries: (in the last year)**

____

____ ☐ NO PRIOR SURGERIES

Skin Disease History: (please check all that apply) *must check "None" if none apply

- Acne
- Actinic Keratosis
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- Other:_____________

____

____

- NONE

- Do you wear Sunscreen? Yes / No If yes, what SPF? _________________________________

***Medications: (Please list all current medications including over the Counter**)

____

____

____ ☐ NO MEDICATIONS

***Allergies: (Please list all allergies)**____

____ ☐ NO ALLERGIES

PATIENT NAME____TODAYS DATE____________________

***ALERTS: (please check all that apply)**

- Allergy to adhesive
- Do you take Blood thinners or aspirin
- Allergy to lidocaine or other anesthetics
- Defibrillator or Pacemaker
- History of MRSA
- Allergy to latex
- Artificial heart valve
- Rapid heartbeat with epinephrine
- Artificial Joint Replacement
- Allergy to topical antibiotics ____________________
- **NO ALERTS APPLY**

Primary Care Physician: ____Office#______/________/________

Referring Physician: ____Office#______/________/_________

Pharmacy Name: ____ Pharmacy#________/________/___________

Pharmacy City: *Pharmacy Zip Code: (required)____

Preferred phone to contact you? Home work mobile ____

Is it okay to leave a detailed message? yes no

Occupation: ____

***Smoking Status: (tobacco, cigarette)**

Never smoke Former Smoker Current smoker Current someday smoker

***Alcohol Use:**

None Less than one drink per day 3 or more drinks per day

Family History (please check all that apply) **Only first-degree relatives*

- Melanoma ______________________________
- Skin Cancer (nonmelanoma) ______________________________
- Psoriasis ______________________________
- Thyroid Disease ______________________________
- Autoimmune Disease ______________________________
- Depression ______________________________
- Diabetes ______________________________
- Hair Loss (Alopecia) ______________________________
- Lupus ______________________________

PATIENT NAME____TODAYS DATE_____________________

***Review of Symptoms: Are you currently experiencing any of the following? (Please check all that apply)**

- Nausea/vomiting
- Hay fever
- Fever or chills
- Dry skin
- Hair loss
- Unintentional weight loss
- Thyroid problems
- Night sweats
- Abdominal pain
- Sore throat
- Headaches
- New lumps or bumps
- Blurry vision
- Problems with healing
- Joint aches
- Rash
- Muscle weakness
- Depression
- Fatigue
- Neck stiffness
- Suicidal thoughts
- Easy bruising
- Photosensitivity
- Problems with bleeding
- Shortness of breath
- Dry eyes
- Problems with scarring
- Dry lips
- Immunosuppression
- Anxiety
- **NO SYMPTOMS**

Other symptoms: ____
____

***FEMALES ONLY (Please check all that apply)**

	NO	Yes / Comments
PREGNANT		
PLANNING PREGNANCY in next 6-12 months		
NURSING		
Hysterectomy		
Tubal ligation		
Ablation		
Birth Control Pills		Name of B/C How long have you been taking this B/C
IUD		
Other contraception		
Abstinence		

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

• Protected health information may be disclosed or used for treatment, payment, or health care operations
• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
• The Practice reserves the right to change the Notice of Privacy Practices
• The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
• The patient may revoke this Consent in writing at any time and all future disclosures will then cease
• The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: ____ Date: _____________________
Printed Name – Patient or Representative

____ Date: ____________________
Signature

Relationship to Patient (if other than patient) ____

Witness: ____ Date: __________________________
Printed Name – Practice Representative

Here at Ginsburg Dermatology Center, our goal is to provide quality medical care in a timely manner. We have adopted the following policies to help us serve you better.

No Shows and Cancellations –. If you fail to show for your appointment or do no cancel your appointment 24 hours in advance, We charge a fee of $50.00; and all Fees will need to be paid before your next appointment. Please note that excessive no-shows or cancellations may result in termination of being your provider.

Copayments - Copayments are due at the time of service. We are contracted with your insurance company and do not waive copayments.

Deductibles – Deductibles owed are due at the time of service. We are contracted with your insurance company and do not waive deductibles.

Referrals – some insurance policies require you to have a referral from your primary care physician, if you fail to get your referral before your office visit there is a chance that your insurance will not pay for that claim, the payment liability will be your responsibility to cover.

☐ Self-Paying patients- We at Ginsburg Dermatology Center are happy to see all patients. However, we are bound by our contracts with the insurance companies to file a claim if you are insured. By checking this box and signing below, you are certifying that you are uncovered by any and all insurance companies.

Cosmetic Patients- All fees are due at the time of service.

Medical Records – We will be happy to provide you with your medical records. You must first sign a medical release form. Fees may apply.

Search Fee	$5.00
Pages 1-25	$1.00 per page
Pages 26+	$.50 per page
Postage	At cost
Storage search	At Cost

By signing below, I understand the policies at Ginsburg Dermatology Center.

____ ______________________

Signature Date