EMERALD COAST DERMATOLOGY & SKIN SURGERY CENTER, PA

Welcome to our office. In order to serve you properly, we will need the following information. (Please Print) All information is strictly confidential. **Full Payment is expected when services are rendered.** Thank you for your cooperation.

PATIENTS NAME LAST, FIRST, MI	AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS S M OTHER	SEX MALE FEMALE
STREET ADDRESS		CITY, STATE, ZIP		HOME PHONE ( )	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		EMPLOYER		WORK PHONE ( )	
NEAREST RELATIVE: NAME, ADDRESS & PHONE NUMBER		EMAIL ADDRESS		CELL PHONE ( )	

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	GUARANTOR PHONE NUMBER
PRIMARY INSURANCE COMPANY NAME		POLICY/ ID NUMBER	GROUP NUMBER
SECONDARY INSURANCE COMPANY NAME		POLICY/ ID NUMBER	GROUP NUMBER

MEDICAL INFORMATION

Reason for your visit today?_____ **Drug Allergies** _____

Please list of medications you are currently taking _____

_____

Please list all major illnesses (high blood pressure, diabetes, etc)_____

Do you have a personal history of skin cancer? _____ **Do you have a family history of skin cancer or melanoma?** _____

Financial Policy

Your insurance policy is a contract between you and your insurance company. Emerald Coast Dermatology cannot guarantee payment for any claim. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT a substitute for payment. Many companies will pay only fixed allowances for procedures and others will pay a percentage of the charge. It is YOUR responsibility to pay any unmet deductible amount, co-insurance, or any other balance not paid by your insurance company. Professional fees for office service are expected in full at the time of service unless previous arrangements were made IN ADVANCE.

I, hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Emerald Coast Dermatology & Skin Surgery Center, P.A. I authorize release of medical records to my insurance carrier. When charges are filed with your insurance carrier with an assignment of benefits to our office, any fees unpaid ***after 45 days will become the patient's responsibility.*** In case of no insurance. I understand that I am solely responsible for all bills incurred and I am expected to pay when services are rendered. I understand that the removal of benign lesions (moles, barnacles, skin tags, etc) is considered a cosmetic procedure and is not subject to insurance payment. Therefore, fees are my financial responsibility.

Please Note: There will be a $30.00 service charge for returned checks. We reserve the right to charge for appointment cancelled or broken without 24 hours of advance notice. How do you intend to pay? [ ] Check [ ] Cash [ ] Credit Card (MC/Visa, Discover, AMEX)

_____ _____ _____

Signature of Patient **Date** **Recommended By**

PHARMACY	PHARMACY PHONE NUMBER
PRIMARY PHYSICIAN	PHONE NUMBER ( )
PRIMARY PHYSICAN ADDRESS	

PATIENT INFORMATION FORM

	YES	NO		YES	NO		YES	NO
Aspirin/Motrin/Advil…….	☐	☐	**Birth Control Pills…. ……**	☐	☐	**Are you pregnant…….**	☐	☐
Coumadin ……...	☐	☐	**Are you Breast Feeding…..**	☐	☐	**Plan on becoming pregnant.**	☐	☐

REVIEW OF SYSTEMS (Current or Past problems with)

	YES	NO		YES	NO		YES	NO
Blood/Bleeding Disorders...	☐	☐	**Arthritis ….……**	☐	☐	**Cancer (non-skin)…….**	☐	☐
Heart Disease……..…...	☐	☐	**Diabetes (sugar) ……**	☐	☐	**Immunologic Disease ……..**	☐	☐
Kidney Disease……...	☐	☐	**High Blood Pressure……..**	☐	☐	**Latex/Nickel/Food Allergy. .**	☐	☐
Liver Disease or Hepatitis...	☐	☐	**Infectious Disease (TB, HIV)**	☐	☐	**Skin Disease…….**	☐	☐
Lung Disease……...	☐	☐	**Blood Transfusions ……**	☐	☐	**Skin Cancer…….…….**	☐	☐
Thyroid Disease……...	☐	☐	**Psychological Disorders...**	☐	☐	**Melanoma…….**	☐	☐

DO YOU

	YES	NO		YES	NO
Have a pacemaker/defibrillator ……	☐	☐	**Have an artificial joint / heart valve…….**	☐	☐
Take antibiotics prior to dental procedures…….	☐	☐	**Form Keloids ……..**	☐	☐

List Surgeries:

_____

_____

Family History (Check the following medical conditions which have occurred in your family)

Disease	Mother	Father	Sibling	None	Disease	Mother	Father	Sibling	None
Acne……..	☐	☐	☐	☐	**Arthritis…….**	☐	☐	☐	☐
Eczema…….	☐	☐	☐	☐	**Asthma……..**	☐	☐	☐	☐
Hives……	☐	☐	☐	☐	**Cancer……**	☐	☐	☐	☐
Melanoma……	☐	☐	☐	☐	**Diabetes……..**	☐	☐	☐	☐
Psoriasis……..	☐	☐	☐	☐	**Hay Fever……**	☐	☐	☐	☐
Skin Cancer……..	☐	☐	☐	☐	**Lupus …….**	☐	☐	☐	☐

SOCIAL HISTORY

	YES	NO	
Do you live alone? ……	☐	☐	
Do you drink alcohol? ……	☐	☐	**Frequency _____**
Do you use recreational drugs?	☐	☐	**Frequency _____**

Occupation_____ Hobbies/Leisure Activity _____

Patient Signature _____ Date _____