LOCKMAN DERMATOLOGY

Patient Information

Referring Physician: _____ **Primary Care Physician** _____

Patient Name _____ _____ _____ M ( ) F ( )
First Middle Last

Mailing Address _____ _____ _____ _____
Street or PO Box City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____/____/____ Social Security # _____ Email-_____

Race: White___ Black___ Hispanic___ Asian___ Am. Indian___ Other_____

Preferred Language: English____ Spanish____ Other_____

(Circle One) Single Married Divorced Widowed Employer _____

Responsible Party (Person Responsible for Payment if different from Patient)

Name _____ _____ _____ Relationship to Patient _____
First Middle Last

Mailing Address _____ _____ _____ _____
Street or PO Box City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ___/___/___ Social Security # _____ Employer _____

Insurance Information
(Copy of insurance card is required. If card not available you will be entered as self pay until card is available)

PLEASE CHECK ONE: INSURANCE _____ **SELF PAY** _____

Primary Insurance Name _____

Primary Policy Holder Name (if different from patient)_____ Date of Birth ____/____/____

Secondary Insurance _____ Other _____

Secondary Policy Holder Name (if different from patient)_____ Date of Birth ____/____/____

Laboratory covered by Insurance* _____
*If you do not know this information please contact Customer Service at your insurance company.

Preferred Pharmacy _____

HIPAA REQUIREMENTS

Lockman Dermatology cares about patient privacy. Health Insurance Portability and Accountability Act (HIPAA) updated their guidelines in September 2013.

___I would like to read these guidelines ___I would not like to read these guidelines. ___I would like a copy of these guidelines. _____ (please initial).

Please provide names of persons that we may release your medical information to:

Name	Phone	Relationship	Emergency Contact
_____	_____	_____	Y / N
_____	_____	_____	Y / N

May non-medical information be left on your answering machine? Yes ____ No ____ Don't have one ___
May we call you at work? Yes ____ No ____ Don't work ____

_____ **Date:**_____
Patient or Parent Signature

AUTHORIZATION TO TREAT, OBTAIN AND RELEASE MEDICAL INFORMATION

I, the undersigned, authorize Dr. Lockman and his staff to perform any procedures and take any photographs as necessary to diagnose and treat my conditions.
I hereby authorize Dr. David S. Lockman to obtain medical records and pharmacy records from other sources as may be needed for treatment.
I hereby authorize Dr. David S. Lockman to release information concerning this patient's treatment to other physicians involved in their care and treatment.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

I, the undersigned, authorize the release of any medical or insurance information to the Social Security Administration and Health Care Financing Administration or the stated insurance company necessary to process insurance claims for services rendered by this facility. I hereby authorize (Ins. Co). _____ *to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.*

PAYMENT POLICY:

****Please make sure we have complete, correct insurance and address information when you check in for <u>each visit</u>. It is <u>your</u> responsibility to make sure we have the information to file your claims correctly the first time. ****

MEDICARE: We are participating providers of the Medicare Program. We will accept assignment on all claims. Patients are responsible for meeting their $166.00 deductible and paying the 20% coinsurance. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

HMO, PPO, OR OTHER MANAGED CARE PATIENTS: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services. Please note: most office procedures go against your deductible, if applicable.

SELF PAY: You will be expected to pay in full for your office exam and any procedures preformed unless arrangements have been made with the office manager.

PATIENT BALANCES: You will be expected to make payment within a timely manner. If the account becomes delinquent with no consecutive payments being made it will be placed with a third party collection agency and an additional 28% fee will be accrued.

Patient or Parent Signature:_____**Date:**_____

Dermatology Medical History

Patient:_____Date:_____

Reason for today's visit:_____

Are you allergic to any medications? □Yes □ No If yes, list below:
1._____ 2. _____

Any nausea, vomiting or diarrhea with antibiotic use? □Yes □ No

Have you ever had dental anesthesia (Novocain)? □ Yes □ No Any bad reaction? □ Yes □ No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals.
1._____ 3._____ 5._____
2._____ 4._____ 6._____

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

Lungs:	YES	NO
Bronchitis - Chronic	□	□
Emphysema	□	□
Asthma	□	□
Shortness of breath	□	□
Wheezing	□	□

Cardiovascular:	YES	NO
High Blood Pressure	□	□
Chest Pain	□	□
Heart Attack	□	□
Irregular Heartbeat	□	□
Phlebitis	□	□
Inflammation of vein	□	□
Blood clots	□	□
Pacemaker	□	□

Other Systemic:	YES	NO
Diabetes	□	□
Excessive thirst/hunger	□	□
Thyroid Low ___ High ___	□	□
Kidney	□	□
If yes, explain _____		
Bladder	□	□
Frequency/burning	□	□
Gastrointestinal	□	□
If yes, what type _____		
Stomach absorptive disorder	□	□
Arthritis/Joint Deformity	□	□
Arthralgia	□	□
Artificial joint	□	□
Convulsions, Epilepsy or Seizures	□	□
Cancers: (non-skin)	YES	NO
If so, please list:_____		

List any other diseases or conditions:_____

Have you had or been exposed to HIV (AIDS) □ Yes □ No

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

Skin:

Have you ever had skin cancer? □ Yes □ No Melanoma? □ Yes □ No
Has anyone in your family had skin cancer? □ Yes □ No BCC___SCC___Melanoma___
Do you have a history of any specific skin disease? □ Yes □ No If yes, _____
Have you ever had a severe sun burn? □ Yes □ No
Do you or have you ever used a tanning bed? □ Yes □ No
Do you bleed easily? □ Yes □ No
Do you develop skin rashes in reaction to □ Medications □ Food □ Environment?_____

Social History:

Do you drink alcohol? □ Never □ Occasionally □ Daily If Daily_____drinks per day
Do you smoke? □ Yes □ No If Yes, how much:_____

Please answer the following questions:

(Women) Are you pregnant? □ Yes □ No Due Date:____/_____/_____
What is your occupation?_____Hobbies?_____

Completed by □ Patient _____Date:_____
□ Medical Assistant _____ Signed by Patient
Initals

_____Date_____
Reviewed by

Preferred Pharmacy Name and Location_____