Joe M. Lehman, M.D.
Michael Lehman, M.D.

Lehman Dermatology Clinic Professional Association

PATIENT INFORMATION

❑New Patient ❑Name Change ❑Address Change ❑Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date _____/_____/_____

Name _____
Last First M.I.

Date of Birth _____/_____/_____ Sex: ❑Male ❑Female SS# _____-____-_____

CONTACT INFORMATION:

Mailing Address _____
City State Zip

Home Phone (____)_____ Cell Phone (____)_____

E-mail Address _____

Employer _____ Work Phone (____)_____

If patient is child, check relationship: ❑Mother ❑Father ❑Other: _____

Next of Kin _____ Phone (____)_____ Relationship _____
(not living at same address)

PARENT, SPOUSE, OR RESPONSIBLE PARTY: SS# _____-____-_____
(if different from patient)

Name _____ Date of Birth:_____/_____/_____
Last First M.I.

Address _____
City State Zip

Home Phone (____)_____Cell Phone (____)_____

E-mail Address _____Employer_____

INSURANCE COVERAGE—PRIMARY: SS# of Policy Holder _____-____-_____

Insurance Co Name _____

Name of Policy Holder (Insured) _____

Policy Holder (Insured) Date of Birth _____/_____/_____ Employer_____

INSURANCE COVERAGE—SECONDARY: SS# of Policy Holder _____-____-_____

Insurance Co Name _____

Name of Policy Holder (Insured) _____

Policy Holder (Insured) Date of Birth _____/_____/_____ Employer_____

Please present insurance card(s) and photo ID to the receptionist so copies may be made.

JOE M. LEHMAN, M.D.
MICHAEL LEHMAN, M.D.

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Lehman Dermatology Clinic
Professional Association

INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITY

PATIENTS WITH INSURANCE

Please read, sign and date at the bottom of the page

IF PRIVATE PAY/NO INSURANCE

Please check the box, read, sign and date at the bottom of the page

❑ PRIVATE PAY/NO INSURANCE

The total patient balance is required to be paid at the time services are provided. We accept cash, checks, VISA, MasterCard and Discover. ***WE DO NOT ACCEPT CARE CREDIT!!!***

Our office participates in various insurance plans. It is your responsibility to:

- Bring your insurance card to every visit.
- Be prepared to pay your copay, deductible and out of pocket at time of service.
- For medical care NOT COVERED under your insurance, 100% of payment is due at time of service.
- Any outstanding balances (owed by you or any family members you are responsible for) are to be paid at time of service.
- If we file a claim to an out-of-network plan as a courtesy, you will still be responsible to pay in full at time services are rendered.
- Payments for any unaccompanied minors (17 years or younger) are due at time of service.

If your insurance requires a referral, it is your responsibility to get that referral from your PCP prior to your appointment. If you do not have a referral, you may want to reschedule your appointment, or you will have to pay 100% of your visit.

Individual insurance companies determine in what situations deductibles will apply. In-office surgeries, procedures, biopsies, pathology fees, removal of pre-cancerous lesions and some injections may fall under your deductible and/or out of pocket. If you have questions as to what part of your visit falls under the deductible, please contact your insurance company prior to your visit.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY COPAY, DEDUCTIBLE AND/OR OUT OF POCKET AT THE TIME OF SERVICE. IF NO REFERRAL IS OBTAINED, I WILL PAY 100% OF MY VISIT.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE
(MUST BE 18 YEARS OR OLDER)

*****PLEASE TURN OVER*****

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print)_____

Relationship to Patient_____

Signature_____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

*****PLEASE TURN OVER*****

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MEDICAL HISTORY

Patient _____ **Patient's Date of Birth** ____/____/____

Reason for today's visit _____ Referring Doctor _____

Are you allergic to any medications? ❑Yes ❑No If yes, list below:

_____

Have you ever had dental anesthesia (Novocaine)? ❑Yes ❑No Any bad reactions? ❑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	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	**Yes**	**No**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of Vein	❑	❑
Blood Clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**Yes**	**No**
Diabetes	❑	❑
Excessive Thirst/Hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/Burning	❑	❑
Gastrointestinal		
Stomach Absorptive Disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited Motion	❑	❑
Artificial Joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions _____

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

Skin:
Have you ever had skin cancer? ❑Yes ❑No
Has anyone in you family had skin cancer? ❑Yes ❑No
Do you have a history of any specific skin diseases? ❑Yes ❑No If yes, _____
Do you have problems with healing? ❑Yes ❑No
Do you develop keloids (scars) after surgery? ❑Yes ❑No
Do you bleed easily? ❑Yes ❑No
Do you develop skin rashes in reaction to ❑Medications ❑Food ❑Environment ❑Bandages ❑Topical Neosporin ❑Other _____

Social History:
Do you drink alcohol? ❑Yes ❑No If yes, _____ drinks per day
Do you use IV drugs? ❑Yes ❑No If yes, what? _____ How often? _____
Do you smoke? ❑Yes ❑No If yes, how much? _____
Have you had or have you been exposed to HIV (AIDS) ? ❑Yes ❑No

Please answer the following questions
(Women) Are you pregnant? ❑Yes ❑No Due Date ____/____/____

What is your occupation? _____ Hobbies? _____

Do we have permission to discuss your medical condition with family members? ❑ Yes ❑ No

If so, name_____ Relationship_____

Completed by ❑Patient
❑Medical Assistant _____ Initials

_____ ____/____/____
Signed by Patient Date

_____ ____/____/____
Reviewed by Date