PATIENT INFORMATION

Patient Name: ____ Sex: ____ Male ____ Female DOB: _______ / _______ / _______

Address (Street, City, and Zip): ____

Social Security #: ____

Home #: ____ Email: ____

Work#: ____ Place of Employment: ____

Cell#: ____ Primary Physician: ____

Pharmacy (Name, Address and Phone#): ____

Emergency Contact (Name and Phone#): ____

How did you hear about our office? ____________________________ Reason for today's visit? ____________________________

Ethnicity: ___ Caucasian ___ African-American ___ Latino ___ Asian ___ Other (please specify): ____________________________

Preferred Language: ____

INSURANCE: Contract Number Group Number Policy Holder/DOB

Primary: ____

Secondary: ____

MEDICAL HISTORY:

Medication Allergies: ____

Current Medications: ____

Past Medical History: ____

Past Surgeries: ____

Have you ever had skin cancer or pre-cancer? ____ Yes ____ No

If yes, which type? ____ Basal Cell ____ Squamous Cell ____ Actinic Keratosis (precancer) ____ Melanoma ____ Dysplastic Nevus ____ Other

What type of treatment did you receive? ____

Are you Pregnant? ____ Yes ____ No Are you nursing? ____ Yes ____ No

FAMILY HISTORY: (Has a blood relative ever had any of the following? Please list relation.)

Melanoma: ____

Other skin cancer: ____

SOCIAL HISTORY:

Marital Status: ____ Single ____ Married ____ Widowed

Do you or have you ever (please specify approximate dates):

Use illicit drugs? ____ Yes ____ No

Use tobacco products? ____ Never ____ Used to but quit ____ Every day ____ Occasionally

Do you drink alcohol? ____ Yes ____ No If "yes", how many alcoholic drinks per day: ____________________________

REVIEW OF SYSTEMS: (If yes, please write brief explanation beside)

____ Artificial heart valve
____ Joint Replacement
____ Pacemaker
____ Blood Clots
____ Thyroid disorders
____ Cold Sores
____ HIV/AIDS
____ Hepatitis

____ Keloid Formation
____ Trouble Healing
____ Excess bleeding due to blood thinners or other reasons
____ Allergies or sensitivity to local anesthesia including epinephrine
____ Recent fever or shortness of breath
____ Anxiety/ Depression

Please include any other information that you would like for us to have about your skin condition:

____

____ I consent to necessary treatment of diagnostic tests/procedure including drug, medicines, performance of operations and conduct of studies that may be conducted by Dr. Flanagan and staff.

____ I understand that I may be charged a S50 fee for a missed appointment.

____ I understand that if (am uninsured or have an insurance that is not accepted at the practice, that I will be responsible for payment IN FULL at the time of service.

____ I understand insurance copays and charges not filled with insurance are due at the time of service. Failure to make payments when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State of Alabama and any other state.

____ I understand that I will be responsible for ANY charges that are not paid by my insurance company. Not all services are covered and I understand that is MY RESPONSIBILITY to know the limits of my coverage and to pay any fees that my insurance company denies. (As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask that you pay in full at your visits and file your own claims.)

____ I understand that most procedures fall under major medical. therefore, I will be responsible for paying the deductible amount at the time of service. Procedures include treatment of skin lesions (including warts, molluscum, moles, skin tags, precancers, skin cancer) by ANY method (including freezing, biopsy, and in-office application of medication.)

____ I authorize the release of medical information to my primary care or referring physician, to consultations if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

____ I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or any related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for the treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.)

____ I am aware that the practice has a Notice of Privacy Policies that contains a section on Patient Rights. I have been given the opportunity to review this notice.

Patient or Responsible Party Signature: ____

Personal Representatives:

To ensure the quality of the services/treatment we provide you, please be advised that post-operative care information may be disclosed to the individual that accompanies you on the date of your services.

I give SVD permission to disclose my medical (i.e. medical and financial) information to:
my spouse ____ my parents ____ adult children ____ Friend: ___________________

SVD may NOT disclose my medical (i.e. medical and financial) information to:
my spouse ____ my parents ____ adult children ____ Friend: ___________________

Patient Signature: ____

(If you are a minor, i.e. under the age of 18, and your parent/guardian is the guarantor of your services, we may disclose your medical and financial information to them for collection of fees you owe.)

Patient Authorization for Practice to Release Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name: ____ Date of Birth: ____

☐ All Medical Records ☐ Lab & Path ☐ Clinical Notes ☐ Billing ☐ Photos

Individuals who may use or disclose this information:

____

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____

Individuals who may receive and use the disclosed information:

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The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by: ____
(Print)

Signature: ____