SHADES VALLEY
DERMATOLOGY

Patient Name: _____ Sex: M or F DOB:____/____/____
Address:_____CITY: _____ ZIP CODE:_____

Social Security #: _____
Home #:_____ Email:_____
Work# _____ Place of Employment: _____

Cell#_____ Primary Physician: _____

Pharmacy name, address and phone#: _____

Emergency Contact Name:_____ Phone #_____
How did you hear about our office? _____ Reason for today's visit? _____

INSURANCE

	Insurance Co	Contract Number	Group Number	Subscriber Name	Subscriber DOB
Primary					
Secondary					
Tertiary					

MEDICAL HISTORY:
Medication Allergies: _____
Current Medications: _____
Current Past Medical History: _____
Past Surgeries: _____

Have you ever had skin cancer or pre-cancer? Y or N If yes, which type? Basal Cell, Squamous Cell, Actinic Keratosis (precancer), Melanoma, Dysplastic Nevus, Other What type of treatment did you receive? _____

Location of cancer or pre-cancer:_____

Are you Pregnant? Y or N Are you nursing? Y or N

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

SOCIAL HISTORY:
Do you or have you ever: (please circle and specify approximate dates) Marital Status: (please circle one)

Use illicit drugs? Y N Single Married Widowed
Use tobacco products? Circle one Never / Used to but quit / Every day / Occasionally

Drink alcohol? Y N

REVIEW OF SYSTEMS: (If yes, circle & write brief explanation beside)
Artificial heart valve Cold Sores Excess bleeding due to blood thinners or other reasons
Joint Replacement
Pacemaker
Blood Clots HIV/AIDS
Hepatitis
Keloid Formation Allergies or sensitivity to local anesthesia including epinephrine
Recent fever or shortness of breath
Thyroid disorders Trouble Healing Anxiety/ Depression

Race: _____
Ethnicity: _____
Preferred Language:_____

_____ 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.

_____ 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: _____ **Date**: _____

PATIENT AUTHORIZATION

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 Shades Valley Dermatology permission to disclose my medical and financial information to only the individuals listed below:

Name	Relationship to Patient	Phone Number