

DEVORE DERMATOLOGY, P.A.

490 Floyd Road

Spartanburg, SC 29307

PATIENT INFORMATION SHEET

DATE: _____ SOCIAL SECURITY # _____

Name _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

Email Address: _____

SEX _____ DATE OF BIRTH _____ MARITAL STATUS _____

FAMILY DOCTOR/INTERNIST/PRIMARY CARE PHYSICIAN _____

REFERRED BY : _____

EMPLOYER _____ STUDENT: YES NO

IF PATIENT IS MARRIED, SPOUSE'S NAME _____ WORK# _____

IF PATIENT IS A CHILD, FATHER'S NAME _____ WORK# _____

MOTHER'S NAME _____ WORK# _____

RESPONSIBLE PARTY

Name (FIRST, MI, LAST) _____ SOCIAL SECURITY NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

OTHER INFORMATION

CONTACT PERSON NOT LIVING WITH YOU _____ RELATIONSHIP TO PATIENT _____

HOME PHONE# _____ CELL PHONE# _____ WORK PHONE# _____

INSURANCE INFORMATION

PRIMARY _____

GROUP# _____ POLICY# _____

POLICY HOLDER _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

SECONDARY _____

GROUP# _____ POLICY# _____

POLICY HOLDER _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

*****PLEASE COMPLETE MEDICAL HISTORY ON REVERSE SIDE*****

FOR OFFICE USE ONLY:

DATE: _____

PHYSICIAN: _____

CHART #:

FINANCIAL AGREEMENT

1. _____ I understand payment is due at the time of service unless arrangements have been made in advance. Visa, Mastercard, Discover, and debit cards are accepted.
2. _____ I authorize DeVore Dermatology to file my insurance(s) as a courtesy to me and understand payment for these services will be mailed directly to this office.
3. _____ I recognize that ultimate financial responsibility for my account remains mine. If my insurance company does not pay the practice within a reasonable period, I will be responsible for the payment. If DeVore Dermatology receives a check from my insurance company they will refund any overpayment in excess of \$5.00. Overpayments under \$5.00 will show as a credit on my account.
4. _____ I understand that not all insurance plans cover all services. In the event my insurance plan determines a service to be "not covered" I will be responsible for the complete charge. I hereby guarantee payment in full of any and all charges for services rendered not covered by any health insurance plan, including all deductible and coinsurance amounts.
5. _____ **I understand that a copayment or coinsurance is required at the time of my visit.**
6. _____ All balances due after insurance must be paid in 60 days unless a written arrangement has been made.
7. _____ As a courtesy to others and to avoid a \$25 service charge, we kindly ask that you give a 2 business day cancellation notice. We realize emergencies do arise and we will handle those on a case by case basis.
8. _____ I am aware that there may be a \$10 administrative charge for phoning in prescriptions and a \$25 administrative charge to complete any miscellaneous forms.

Patient Signature (or parent if a minor) **Print Name** **Date**

If you are not the patient, please state your relationship _____

**MEDICARE PATIENTS ONLY:
 STATEMENT TO ASSIGN MEDICARE BENEFITS TO PHYSICIAN OR SUPPLIER**

Patient's Name: _____ Medicare Number: _____
 "I request that payment of authorized Medicare Benefits be made on my behalf to DeVore Dermatology, P.A. for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services." Signature _____ Date _____

STATEMENT TO ASSIGN MEDIGAP BENEFITS TO PHYSICIAN OR SUPPLIER (SUPPLEMENTAL)

"I authorize Medicare to file my supplemental (Medigap) insurance. I request that payment be made to DeVore Dermatology, P.A. for any services furnished to me by that physician. I authorize the release of any medical information necessary to process this claim." Signature _____ Date _____

MEDICARE NON-COVERED SERVICES WAIVER

"I understand that there is a \$10.00 charge for phoned in prescriptions (CPT 99371) and a \$25 charge for missed appointments or appointments cancelled with less than a 2 business day notice. I am aware that these charges are not covered by Medicare and that I will be financially responsible for this charge if and when it is incurred.

Signature _____ Date _____ Witness _____

MEDICAL HISTORY

CHART # _____

Please thoroughly complete this history form to help ensure the best possible medical treatment.

Patient: _____ Age: _____ Today's Date: _____

Reason for visit: _____

How long have you had this problem? _____

What treatment have you used on your own? _____

What prescription treatments have been used? _____

Are you **ALLERGIC TO ANY MEDICATIONS**? If so, please list: _____

List any **medications** you are **currently taking** and circle the approximate **length of time** that you have been on the medication:

- | | | | |
|----------|--------------------|-----------|-------------------|
| 1) _____ | less than one year | 1-2 years | more than 3 years |
| 2) _____ | less than one year | 1-2 years | more than 3 years |
| 3) _____ | less than one year | 1-2 years | more than 3 years |
| 4) _____ | less than one year | 1-2 years | more than 3 years |
| 5) _____ | less than one year | 1-2 years | more than 3 years |
| 6) _____ | less than one year | 1-2 years | more than 3 years |
| 7) _____ | less than one year | 1-2 years | more than 3 years |
| 8) _____ | less than one year | 1-2 years | more than 3 years |

**If you are taking more than 8 medications, please continue on the back of this form.

Have you had **aspirin or ibuprofen** in the last two weeks? yes no

Have you ever had **dental anesthesia** (novocaine)? yes no

If yes, any bad reactions? _____

Do you smoke? yes no If yes, how much? _____

Do you drink alcohol? yes no If yes, how many drinks per day? _____

Do you use IV drugs? yes no If yes, what kind? _____

Have you ever had or been exposed to HIV (AIDS)? yes no

Have you ever had or been exposed to Hepatitis? yes no

When you are exposed to the sun do you: Tan only Tan and Burn Burn

Have **you** ever had **skin cancer**? yes no If yes, was it melanoma? _____

Has a **family member** had **skin cancer**? yes no

If yes, was it **melanoma**? yes no If yes, whom? _____

Do you have a history of any specific **skin diseases**? yes no

If yes, please list the type: _____

Do you have artificial joints? yes no

Do you bleed easily? yes no

Do you faint easily? yes no

(Women) Are you Pregnant? yes (due date) _____ no

What **blood relative** has:

Diabetes _____ Asthma _____ Hay fever _____

Skin disease _____ What type? _____

Do **you** have any of the following conditions?

Diabetes _____ Asthma _____ Hay fever _____ Heart disease _____

Lung disease _____ Stomach ulcers _____ High blood pressure _____

