SKIN P.C.
DERMATOLOGY CENTER
ELKHORN | FREMONT | WAHOO | COLUMBUS
www.skinpc.com

_____New Patient _____Update **Today's Date: _____**

Name: Last_____ First_____ MI_____

Preferred Name: _____

Date of Birth: _____/_____/_____ Social Security Number: _____/_____/_____ Age:____

Marital Status: (circle) Single Married Separated Divorced Widowed **Gender:** Male or Female

Address: _____ Apt #: _____

City: _____State:_____ **Zip**: _____

Home #: _____ **Work #**: _____ **Cell #**:_____

Email _____Employer_____

Preferred Method of Contact for Reminder Calls: Phone ____ Text ____ Email ____

Primary Care Provider: _____ Phone: _____

Referring Doctor:_____

How did you hear about our office? _____

PRIMARY INSURANCE ***SECONDARY INSURANCE***

Policy holder: _____ **Policy Holder: _____**

Policy Holder's DOB: _____ **Policy Holder DOB: _____**

PREFERRED PHARMACY

Name: _____ **Phone: _____**

Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone:_____**Relationship**:_____

Name: _____

Phone:_____**Relationship**:_____

May we share medical and billing information with these individuals: _____YES **_____**NO
I give permission for Skin P.C. to leave a message and/or medical information on my home or cell phone. (This includes biopsy information) Yes_____ No_____

ALL PATIENTS

Patient Portal

Our office utilizes a patient portal which will allow you to access your visit notes and contact a nurse for prescription refills. You will be sent a link via email that you will need to activate within 24 hours.

Email:_____

- Do you have a Primary Care Physician? Yes or No

- **Have you seen your Primary Care Physician (PCP) in 2017?** Yes or No

- **Have you received your flu vaccination (October 2017 – March 2018)?** Yes or No

- **Have you been out of the country within the last twelve (12) months?** Yes or No

PATIENTS 65 AND OLDER:

Vaccinations

Have you received a pneumonia vaccination? Yes or No

Advance Care/Living Will

Do you have a living will? Yes or No

Do you have a health care designee in the event you are unable to make your own medical decision?

Yes or No?

Designee's Name_____ Phone #_____

Do you have a Do Not Resuscitate (DNR) in place? Yes or No

Patient Name:_____ **DOB**:_____ **Date**:_____

Past or Present Medical Conditions (circle all that apply)

Lung Disease Bleeding Problems Heart Disease Asthma Hepatitis
Hypertension Pacemaker Diabetes Hay Fever Drug or Alcohol Abuse
Cancer (breast, prostate, colon) High Cholesterol Congestive Heart Failure
COPD Coronary Heart Disease **Any other diseases:** _____
Recent Surgery:_____

Current Oral Medications (including birth control) _____

_____

Are you a past or present smoker? ___ Yes ___ No **Alcohol Use?** ___ Yes ___No

Illicit Drug Use? ___ Yes ___ No

Have you had an allergic reaction to medications?
Penicillin_____ Lidocaine_____ Other _____

Personal history of skin cancer? _____ Yes _____ No

If yes, was the skin cancer: ____ Basal Cell Carcinoma ____Squamous Cell Carcinoma ____Melanoma

Family history of skin cancer? _____ Yes _____ No

If yes, was the skin cancer: ____ Basal Cell Carcinoma ____Squamous Cell Carcinoma ____Melanoma

GENERAL OFFICE POLICIES:

A Notice of Privacy Practices is available for your review. Please ask the front desk for your copy. My signature below indicates that I have received and/or reviewed a copy of the office's Notices of Uses and Disclosure of Protected Medical Information (Notice of Privacy Practices).

FINANCIAL POLICY:

I agree to pay Skin P.C. for all services deemed not covered by my insurance plan. I also understand it is my responsibility to verify any "Out-of-Network" coverage for insurance that Skin P.C. does not participate. For those insurance plans that Skin P.C. does not participate with, I agree to pay balances that my insurance plan indicates are my responsibility. It is my responsibility to become familiar with the agreement between myself, and my insurance plan. I understand that if a procedure is performed that requires pathology; a separate bill may be sent for payment by the laboratory. I agree/understand that co-pays and outstanding balances are due at the time of my visit. I also authorize payment of medical benefits to the physician for services provided.

CONSENT TO TREAT:

I hereby give Skin P.C. my permission to perform the necessary procedure(s)/treatments after the provider has fully explained, in terms clear to me, the effects and nature of the procedure(s)/treatment to be performed, foreseeable risks involved, and alternativ5e methods of treatments. I understand I will be given the opportunity to ask any questions regarding this procedure(s)/treatment. I will follow after care instructions. I authorize Skin P.C. to view my external prescription history via the EMA service in order to provide accurate prescription history, reduce medication errors and enhance patient safety. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. **I have read and understand the above policies.** This signature will also be used as "signature on file" for insurance purposes including any medical information necessary to process the claim. I also give permission for medical photographs to be taken and they may be used for educational purposes.

Patient /Legal Guardian (Print Name) _____

Patient /Legal Guardian Signature _____

Date: ____/____/_____