INTEGRATED
DERMATOLOGY
OF YUMA

Advance Beneficiary Notice of Non coverage (ABN)

Name: _____ **DOB:** _____

Date of Service: _____ **Estimated Charge:** $100.00 and up

Possible non covered services are: Skin tag removal, warts, skin lesions, laser treatment and benign destructions.

Reason for non-coverage by insurance carrier: Not medically necessary

We go to great lengths to verify the amount and type of coverage you are allowed under your plan. We can quote your estimated coverage; however final determination of benefits will not occur until the insurance company receives your claim. In the event the plan sponsor determines that you are not eligible at the time of service, or applies the charges to the deductible/coinsurance, by signing this statement you agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Patient signature: _____ **Date:** _____

INTEGRATED DERMATOLOGY OF YUMA

Ronald M. Harris, MD
Sandra Corbin, PA-C
Taylor Todd, PA-C

REGISTRATION INFORMATION

PATIENT INFORMATION

DATE:

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX: ☐MALE ☐FEMALE

SPOUSE'S NAME	HOME #	WORK #

EMAIL ADDRESS	MOBILE #	MARTIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

RESPONSIBLE PARTY INFORMATION (If other than self)

LAST NAME	FIRST NAME	MI	HOME #

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK #

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER

MOTHER'S NAME	MOTHER'S BIRTHDATE	FATHER'S NAME	FATHER'S BIRTHDATE

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:

PATIENT'S EMPLOYER OR SCHOOL ADDRESS	☐FULL-TIME ☐PART-TIME ☐SELF EMPLOYED

CITY	STATE	ZIP	☐NOT EMPLOYED ☐ACTIVE MILITARY ☐RETIRED

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME #

ADDRESS	CITY	STATE	ZIP	WORK #

INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $

PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

SECONDARY INSURANCE	CARDHOLDER	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

PHARMACY INFORMATION-Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.

PHARMACY NAME	PHARMACY PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

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HEALTH QUESTIONNAIRE

Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Referred By: _____

Primary Care Physician: Dr. _____ **Phone:** _____

Reason for Visit (One or Two Main Problems to Address Today): _____

_____

Duration of Problem: _____

Treatment: _____

Aggravating factors: _____

Current Medications (please include OTC, herbs, vitamins, supplements): _____

_____

_____

Allergies to Medication: ☐None ☐ _____

Other Allergies: ☐None ☐Latex ☐Bandages/Adhesive

☐Topical Antibiotic (Neosporin or other) _____

Have you ever had any bad reaction to local anesthesia? ☐No ☐Yes ☐Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, if so what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Where? _____ **When?** _____

Treatment? _____

Has anyone if your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? _____

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