Patient Information			
Last Name:	First Name:		MI:
Address:			
City:	State: ZIP:		Gender
Home Phone:	Work Phone:		
Cell Phone:	Preferred: Home ☐ Work ☐ Cell ☐		
E-mail:	Marital Status: M ☐ S ☐ D ☐ W ☐		
Date of Birth: SSN:	Race: Hispanic?		
Occupation:	Preferred Language:		
Employer:	Primary Physician:		
Emergency Contact:	Relation:	Phone:	

Insurance Information			
Complete this section only if the patient is not the primary subscriber			
Subscriber Name:			
Address:	DOB:	SSN:	
City:	State: ZIP:		Gender
Home Phone:	Work Phone:		
Cell Phone:	E-mail:		
Relation to Patient:	Employer:		

Referral Source		
◯ Verizon Phone Book	◯ Newspaper	◯ Relative/Friend:_____
◯ Dex Knows/Century Link	◯ Yellow Book	◯ Internet
◯ Lake Ozark Yellow Pages	◯ Sign Out Front	◯ Jefferson City Magazine
◯ Physician:_____	◯ Facebook	◯ Previous Patient

Release of Information
New HIPAA Laws prevent us from releasing lab or pathology results to anyone other than the patient. This upsets some patients who have their spouse, children, or other person to call for results or who answers the phone when we call to give results. **If you wish to authorize us to discuss test results with anyone besides yourself, please list their name and phone #.**
1
2

Angel Allen Dermatology, LLC has established a Notice of Privacy Practices Policy in order to comply with The Health Insurance Portability Act of 1996 (HIPAA). A copy of this policy is available upon request. I authorize Angle Allen Dermatology to use and disclose protected health information to carry out treatment, payment, and healthcare options. I certify that the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by my insurance.

Signature:_____ Date:_____

Angel Allen Dermatology, LLC

Financial Policy Disclaimer –Effective June 1, 2013

Insurance Verification

- Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility. It is the patient's responsibility to ensure that Angel Allen Dermatology is a contracted provider within their policy and to understand the benefits outlined in that policy. HMO plans almost always require a referral from a primary care physician. If you are unsure whether you need a referral, please call the Member Services line on that back of your card. Failure to obtain the proper referral will result in denial of claims by your insurance.

Payment Due at Time of Service

- Deductible Plan: Our policy is to collect a partial payment at time of service. Once we receive an Explanation of Benefits (EOB) report from the patient's insurance company, we will bill for the remaining balance toward either deductibles or co-insurance.
- Co-Payment Plan: All co-payments will be collected at time of service.

Collection of Patient Balance

- If the EOB shows the patient has an outstanding responsibility, the patient will receive a bill outlining the charges. Payment is due within 30 days of receipt of bill.
- In the event a bill is disputed, you must notify us within 30 days, if not, the bill will be presumed valid and due.
- Failure to remit payment will result in account begin sent to a collection agency.

Returned Checks

- A fee of $25.00 will be charged for all checks that are returned to us.

By signing this form, I authorize Angel Allen Dermatology to bill my insurance company and payment to go directly to Angel Allen Dermatology. I understand that all charges are my responsibility and I will pay for all the charges that are deemed my responsibility by my insurance company. I understand that I am responsible for all charges due to my negligence to inform Angel Allen Dermatology of any changes to my insurance carrier or policy.

Self Pay / No Insurance

- A partial payment of $100 will be due prior to your appointment.
- Any remaining balance from appointment will be due upon checking out. Account must be paid in full prior to leaving the office.
- If charges do not accumulate to $100, any over-payment will be credited to your account and will be available as a refund at the end of the current billing cycle.

Cosmetic Services

- Payment is due in full on date of service.

_____ _____

Patient Name (Printed) **Date**

_____ _____

Patient / Legal Guardian Signature **Responsible Party Name** (Printed)
(if applicable)

MEDICAL HISTORY

Name_____ Date_____

Disease/Medical Condidtion History

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ BPH
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE

Other:_____

Surgical History:

- ☐ Appendix
- ☐ Bladder
- ☐ Breast – Lump R L
- ☐ Breast – Mastectomy R L
- ☐ Breast – Biopsy R L
- ☐ Breast – Other
- ☐ Colon – Cancer
- ☐ Colon – Diverticulitis
- ☐ Colon – Inflammatory Bowel Disease
- ☐ Gall Bladder
- ☐ Heart – Coronary Artery Bypass
- ☐ Heart – PTCA
- ☐ Heart – Mechanical Valve Replacement
- ☐ Heart – Transplant
- ☐ Joint – Hip R L
- ☐ Joint – Knee R L
- ☐ Kidney – Biopsy
- ☐ Kidney – Removal
- ☐ Kidney – Stone Removal
- ☐ Kidney – Biopsy
- ☐ Ovaries – Endometriosis
- ☐ Ovaries – Cancer
- ☐ Ovaries – Cyst
- ☐ Prostate – Cancer
- ☐ Prostate – Biopsy
- ☐ Prostate – TURP
- ☐ Spleen
- ☐ Testicles
- ☐ Uterus – Fibroids
- ☐ Uterus – Cancer
- ☐ NONE

☐ Other:_____

MEDICAL HISTORY (continued)

Name_____ Date_____

Skin Condition History:

- ☐ Acne
- ☐ Actinic Keratoses -pre-cancers
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburn
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking/Itching Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ NONE
- ☐ Other:_____

Do you use a sunscreen on a regular basis? YES☐ NO☐
What kind? _____

Do you currently use a tanning bed? YES☐ NO☐
How many times have you used a tanning bed? #_____
Have you previously used a tanning bed, but currently do not? YES☐ NO☐

Do you have any family history of skin cancer? YES☐ NO☐
What kind? Basal Cell Carcinoma☐ Squamous Cell Carcinoma☐ Melanoma☐ Unknown☐

What family member(s)?_____

Please list all medications you are currently taking:

_____

_____

_____

_____

Please list any allergies you have to medications:

_____

_____

_____

_____

Social History:

- ☐ Alcohol – none
- ☐ Alcohol – less than 1 drink daily
- ☐ Alcohol – 1-2 drinks daily
- ☐ Alcohol – more than 3 drinks daily
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoked

What pharmacy do you use? _____