



PATIENT INFORMATION FORM

Please complete all fields on both sides of this form in ink and sign where indicated.

PATIENT INFORMATION

Date ___/___/___

Patient Name (last, first, middle initial) _____ Preferred Name _____

Date of Birth: ___ / ___ / ___ Social Sec. # _____ Gender: Male Female

Mailing Address: Street _____

City _____ State _____ ZIP _____

Home Phone: (____) _____ Mobile Phone: (____) _____

Email Address: _____

(We will never give out your email address without your written permission.)

Primary Care Physician: _____ Referring Physician: _____

PARENT, SPOUSE OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name (last, first, middle initial) _____

Date of Birth: ___ / ___ / ___ Social Sec. # _____ Gender: Male Female

Mailing Address: Street _____

City _____ State _____ ZIP _____

Home Phone: (____) _____ Mobile Phone: (____) _____

Email Address: _____

INSURANCE INFORMATION

INSURANCE COVERAGE – PRIMARY

Insurance Company Name _____

Policy/ID Number _____

Name of Policy Holder (Insured) _____ Date of Birth: ___ / ___ / ___

Relationship to Insured: Self Spouse Child Other _____

INSURANCE COVERAGE – SECONDARY (IF APPLICABLE)

Insurance Company Name _____

Policy/ID Number _____

Name of Policy Holder (Insured) _____ Date of Birth: ___ / ___ / ___

Relationship to Insured: Self Spouse Child Other _____

RELEASE OF INFORMATION

Other than yourself, with whom may we discuss your medical information?

(Please give the person's name and relationship to you.)

EMERGENCY CONTACT INFORMATION

Name of Friend or Relative: _____

Relationship to Patient: _____

Address: _____

Home Phone: _____

Mobile Phone: _____

LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Epiphany Dermatology and its related companies. I understand that I am financially responsible for any balance. I also authorize Epiphany Dermatology, its related companies, or insurance company to release medical information required to process claims.

Notice of Privacy Practices: I have read or been offered a copy of Epiphany Dermatology's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.

Authorizations: I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that medical treatment may include a review of medical history, discussion of reason for visit and medical photographs of the area being discussed. I authorize Epiphany Dermatology and its related companies to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Epiphany Dermatology's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Epiphany Dermatology.

Financial Responsibility: Health insurance benefits are verified as a courtesy and are an estimate only. Final patient responsibility is based on the insurance explanation of benefits once the claim is processed.

Consent for Communication: I understand Epiphany Dermatology will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.

Payment Policy: Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Epiphany Dermatology and its related companies.

Late or Missed Appointment Policy: We require a 24-hour cancellation notice if you are not able to keep your appointment. No-show appointments are subject to a no-show fee (including surgery and cosmetics) as missed appointments prevent other patients from seeing our providers in a timely fashion. See office "Late or Missed Appointment Policy" for pricing.

Legal: This form applies to Epiphany Dermatology and its related companies.

Patient Rights: I have read or been offered a copy of Epiphany Dermatology Patient Rights.

Patient Rights Document Received: Received Declined.

SIGNATURE

Patient / Guardian Signature: _____ Date: _____



MEDICAL HISTORY AND INTAKE FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Reason for Visit, location of problem, duration of problem: _____

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

- | | | |
|---------------------------------------|-------------------------|--------------------|
| Allergies (Seasonal) | Heart Valve Replacement | Lumpectomy |
| Asthma | High Blood Pressure | Lupus / Rheumatoid |
| Bleeding Disorder (or bleeding issue) | High Cholesterol | Arthritis |
| Cancer: _____ | HIV/AIDS | Mastectomy |
| Coronary Artery Bypass | Joint Replacement | Organ Transplant |
| Depression | Kidney Transplant | Thyroid Disease |
| Diabetes | Liver Disease | NONE |
| Fever Blister | | |

DO YOU HAVE A HISTORY OF SKIN CANCER OR SKIN DISORDERS?

(Examples: acne, actinic keratosis, basal cell, melanoma, psoriasis, squamous cell) Yes _____ No _____

If yes, please indicate condition or disorder: _____

FAMILY HISTORY OF SKIN CANCER INCLUDING MELANOMA? Yes _____ No _____

If yes, whom: _____

MEDICATIONS: (Enter all current medications including non-prescription and birth control; if none mark N/A)

ALLERGIES: (Please enter all allergies including allergies to medications; if none mark N/A)

SOCIAL HISTORY:

Do you smoke? Yes ___ No ___ If yes, how much? _____

Do you drink alcohol? Yes ___ No ___ If yes, how much? _____

REVIEW OF SYSTEMS: (CHECK ALL THAT APPLY)

- | | | |
|------------------------|--------------------------------|---------------------------|
| Problems with bleeding | Problems with scarring/keloids | Night sweats |
| Problems with healing | Fever or Chills | Unintentional weight loss |
| | | Joint pain |

ALERTS: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

- | | |
|--------------------------------|--------------------------------------------------------|
| Allergy to Adhesive | MRSA |
| Allergy to Lidocaine | Pacemaker |
| Allergy to Topical Antibiotics | Require antibiotics prior to a surgical procedure |
| Artificial Heart Valve | Rapid heart beat with Epinephrine |
| Artificial Joint Replacement | Currently pregnant or currently trying to get pregnant |
| Blood Thinners | Breastfeeding |
| Defibrillator | NONE |

PREFERRED PHARMACY

Preferred Pharmacy Name: _____ Telephone (if known): _____

Address (or cross streets): _____ City: _____