NASHVILLE SKIN COMPREHENSIVE DERMATOLOGY CENTER

PLEASE PRINT

CONTACT INFORMATION

LAST NAME_____ FIRST NAME _____ MIDDLE INITIAL_____

GENDER (circle one): MALE / FEMALE SSN _____ MARITAL STATUS _____ BIRTHDATE _____

RACE_____ ETHNIC GROUP _____ PREFERRED LANGUAGE _____
EX: AFRICAN AMERICAN EX: HISPANIC EX: ENGLISH

STREET ADDRESS CITY STATE ZIP

PRIMARY PHONE SECONDARY PHONE WORK PHONE

E-MAIL YOUR EMPLOYER PRIMARY CARE PROVIDER

PREFERRED PHARMACY PHARMACY ADDRESS PHARMACY PHONE

YOU MAY CONTACT ME AT: (check all) ____HOME ____CELL ____WORK

MAY WE LEAVE VOICEMAILS REGARDING YOUR HEALTH INFORMATION? (check one) ____YES ____NO

WERE YOU REFERRED BY ANOTHER PROVIDER? ____YES ____NO IF YES, WHO? _____

HOW DID YOU HEAR ABOUT US?_____

INSURANCE

PRIMARY INSURANCE RELATION SECONDARY INSURANCE RELATION

NAME OF POLICY HOLDER ADDRESS (IF DIFFERENT) NAME OF POLICY HOLDER ADDRESS (IF DIFFERENT)

POLICY HOLDER'S DOB POLICY HOLDER'S DOB

POLICY HOLDER'S SSN POLICY HOLDER'S SSN

PLEASE LIST CURRENT MEDICATIONS

(INCLUDING VITAMINS AND OVER-THE-COUNTER)

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

ARE YOU ON ANY BLOOD THINNERS? ___YES ___NO

___ASPIRIN ___COUMADIN ___PLAVIX ___XARELTO ___VITAMIN E

MEDICATION ALLERGIES (LIST ALL THAT APPLY)

1.	2.	3.	4.
5.	6.	7.	8.

CONTINUED ON REVERSE SIDE

PLEASE PRINT

PAST MEDICAL HISTORY

(CHECK ALL THAT APPLY)

___SKIN CANCER
(INDICATE TYPE BELOW)
___MELANOMA
___BASAL CELL CARCINOMA
___SQUAMOUS CELL CARCINOMA

___PSORIASIS
___ECZEMA
___LUPUS
___SCLERODERMA
___ATYPICAL MOLES
___DIABETES
___HEART ATTACK

___STROKE
___BLOOD CLOT
___ATRIAL FIBRILLATION
___SEIZURES
___THYROID PROBLEM
___ANEMIA
___EMPHYSEMA

___HIGH BLOOD PRESSURE
___HEPATITIS B
___HEPATITIS C
___HIV
___TUBERCULOSIS
___BLEEDING PROBLEM

HAVE YOU HAD CANCER OTHER THAN SKIN CANCER? ___YES ___NO IF YES, WHAT TYPE? _____

HAVE YOU HAD AN ORGAN TRANSPLANT? ___YES ___NO IF YES, WHAT TYPE? _____

HAVE YOU HAD A JOINT REPLACEMENT? ___YES ___NO IF YES, WHAT JOINT AND WHAT YEAR? _____

HAVE YOU HAD A HEART VALVE REPLACEMENT? ___YES ___NO

DO YOU HAVE A PACEMAKER OR DIFIBRILLATOR? ___YES ___NO

FEMALES ONLY: Are pregnant?___YES ___NO FEMALES ONLY: Are you currently breastfeeding? ___YES ___NO

FAMILY HISTORY

PLEASE INDICATE ANY CONDITIONS PRESENT IN IMMEDIATE FAMILY

MELANOMA ___YES ___NO IF YES, RELATION_____

PSORIASIS ___YES ___NO IF YES, RELATION_____

LUPUS ___YES ___NO IF YES, RELATION_____

CANCER ___YES ___NO IF YES, RELATION AND TYPE _____

OTHER ___YES ___NO IF YES, WHAT AND RELATION _____

SOCIAL HISTORY

DO YOU SMOKE? ___YES ___NO IF YES, HOW MANY YEARS? _____ DO YOU CONSUME ALCHOHOL ON A REGULAR BASIS? ___YES ___NO

REVIEW OF SYSTEMS

PLEASE INDICATE ANY SYMPTOMS YOU HAVE RECENTLY EXPERIENCED
(CHECK ALL THAT APPLY)

___FEVER
___CHILLS
___NIGHT SWEATS
___WEIGHT LOSS
___FATIGUE
___HEADACHE
___SIEZURES
___DIZZINESS
___NUMBNESS

___COUGHING
___WHEEZING
___BLOODY SPUTUM
___SHORTNESS OF BREATH
___NOSE BLEEDS
___MOUTH ULCERS
___DRY EYES
___BLURRED VISION

___CHEST PAIN
___PALPITATIONS
___ENLARGED LYMPH NODES
___NAUSEA
___VOMITING
___DIARRHEA
___ABDOMINAL PAIN
___EASY BLEEDING

___BLOOD IN URINE
___URINARY PAIN
___FREQUENT URINATION
___GENITAL SORES
___IRREGULAR MENSES
___ARTHRITIS
___MUSCLE ACHES

___MUSCLE CRAMPS
___HAIR LOSS
___EXCESS HAIR
___INCREASED SWEATING
___ANXIETY
___DEPRESSION
___SUICIDAL THOUGHTS

I, the undersigned, authorize Nashville Skin and staff to provide medical service to me and authorize the disclosure of protected health information for purpose of payment, health care operations, and treatment.

_____ _____ _____ _____

PATIENT SIGNATURE DATE PROVIDER SIGNATURE DATE

NASHVILLE SKIN COMPREHENSIVE DERMATOLOGY CENTER

AGREEMENT TO PAY

In order to establish an optimal relationship and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required at the time services are rendered unless you are covered by an insurance company with which Nashville Skin participates. We accept payment in the form of cash, check, or credit card.

I understand that it is my responsibility to present accurate, current insurance coverage information at time of check in. At that time, I will be asked to pay for all services not covered, deductible amounts, co-pays, past due balances, as well as balances due resulting from invalid insurance information. For patients with HMO coverage or other third party insurance that require authorizations, I will be held responsible for payment if this referral authorization is not provided at the time of service. I, as the patient or responsible party for the patient, agree to be responsible for charges or services referred to another physician or laboratory by any physician/practitioner of Nashville Skin.

I understand that failure to make payment when due is the basis for legal action, and agree to pay any and all cost of collection, including attorneys' fees.

I understand it is the policy of Nashville Skin to collect any outstanding balance before additional services are rendered.

I authorize and request that payment by an authorized insurance company be made payable to Nashville Skin on my behalf for the services furnished to me by the physician(s)/practitioner(s) of Nashville Skin.

This signature verifies the agreement to the above as the patient or the responsible party for the patient.

Signature:_____ **Date:**_____

NO SHOW POLICY (EFFECTIVE 9/1/2009 & 4/1/2012)

I understand that I will be allowed one missed (no show) appointment without a penalty. After a second no show and every no show thereafter, I will be charged a $30.00 fee. 24 hours cancellation notice is required if you are unable to keep your appointment. I understand that I will be charged a $100 fee for any missed (no show) surgery/excision appointment. 24 hours cancellation notice is required if you are unable to keep your appointment.

Signature:_____ **Date:**_____

MEDICARE POLICY

I request that payment of authorized Medicare benefits be made on my behalf to Nashville Skin for any services or items furnished to me by the physician(s)/practitioner(s) of Nashville Skin. I further request authorized Medigap benefits be made on my behalf to Nashville Skin. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid services and its agents and/or my Medigap carrier, any information needed to determine these benefits or benefits payable for related services.

Signature:_____ **Date:**_____

Revised 3/27/12

Please see reverse side ⇨

NASHVILLE SKIN COMPREHENSIVE DERMATOLOGY CENTER

AUTHORIZATION TO REVEAL MEDICAL AND BILLING INFORMATION

I authorize Nashville Skin and staff to reveal to the following individuals, as needed, information regarding my protected health information and billing information. I understand that once this information is disclosed to these individuals, Nashville Skin will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to Nashville Skin.

1. Name:_____Relationship:_____
2. Name:_____Relationship:_____
3. Name:_____Relationship:_____

Signature:_____**Date:**_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have read and understand the Privacy Practice notice provided to me by Nashville Skin. I understand that this notice will be in effect until further notice from Nashville Skin.

Signature:_____**Date:**_____

AUTHORIZATION TO OBTAIN OUTSIDE MEDICAL RECORDS

Nashville Skin has my authorization to request my Protected Health Information from another physician, hospital or other personnel involved with my care in order to facilitate my treatment.

Signature:_____**Date:**_____

Responsible Party (Guarantor) Statement (if not the patient)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____/_____/_____ Gender: M F SSN _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

Relationship to Patient: spouse child guardian other _____

Signature: _____ **Date:** _____