

NASHVILLE COMPREHENSIVE
SKIN 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)

<input type="checkbox"/> SKIN CANCER (INDICATE TYPE BELOW)	<input type="checkbox"/> PSORIASIS	<input type="checkbox"/> STROKE	<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> MELANOMA	<input type="checkbox"/> ECZEMA	<input type="checkbox"/> BLOOD CLOT	<input type="checkbox"/> HEPATITIS B
<input type="checkbox"/> BASAL CELL CARCINOMA	<input type="checkbox"/> LUPUS	<input type="checkbox"/> ATRIAL FIBRILLATION	<input type="checkbox"/> HEPATITIS C
<input type="checkbox"/> SQUAMOUS CELL CARCINOMA	<input type="checkbox"/> SCLERODERMA	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> HIV
	<input type="checkbox"/> ATYPICAL MOLES	<input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> TUBERCULOSIS
	<input type="checkbox"/> DIABETES	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> BLEEDING PROBLEM
	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> EMPHYSEMA	

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	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, RELATION _____
PSORIASIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, RELATION _____
LUPUS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, RELATION _____
CANCER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, RELATION AND TYPE _____
OTHER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, WHAT AND RELATION _____

SOCIAL HISTORY

DO YOU SMOKE? YES NO IF YES, HOW MANY YEARS? _____ DO YOU CONSUME ALCOHOL ON A REGULAR BASIS? YES NO

REVIEW OF SYSTEMS

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

<input type="checkbox"/> FEVER	<input type="checkbox"/> COUGHING	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> BLOOD IN URINE	<input type="checkbox"/> MUSCLE CRAMPS
<input type="checkbox"/> CHILLS	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> PALPITATIONS	<input type="checkbox"/> URINARY PAIN	<input type="checkbox"/> HAIR LOSS
<input type="checkbox"/> NIGHT SWEATS	<input type="checkbox"/> BLOODY SPUTUM	<input type="checkbox"/> ENLARGED LYMPH NODES	<input type="checkbox"/> FREQUENT URINATION	<input type="checkbox"/> EXCESS HAIR
<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> GENITAL SORES	<input type="checkbox"/> INCREASED SWEATING
<input type="checkbox"/> FATIGUE	<input type="checkbox"/> NOSE BLEEDS	<input type="checkbox"/> VOMITING	<input type="checkbox"/> IRREGULAR MENSES	<input type="checkbox"/> ANXIETY
<input type="checkbox"/> HEADACHE	<input type="checkbox"/> MOUTH ULCERS	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> SEIZURES	<input type="checkbox"/> DRY EYES	<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> MUSCLE ACHES	<input type="checkbox"/> SUICIDAL THOUGHTS
<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> BLURRED VISION	<input type="checkbox"/> EASY BLEEDING		
<input type="checkbox"/> NUMBNESS				

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

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 

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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: _____