High Plains Dermatology Center, P.A.

PATIENT INFORMATION SHEET

Today's Date _____ Who referred you: _____

PATIENT'S NAME _____
(Last) **(First)** **(Middle)** **(Jr./Sr.)**

Patient's Mailing Address_____
(Street) (Apt.) (City, State) (Zip Code)

Phone Number for Appointment Reminders_____

Patient's Home Phone#_____ Patient's Cell Phone#_____

Patient's Employer _____ Patient's Work Phone# _____

Patient's Social Security # _____ Marital Status: ☐ M ☐ W ☐ D ☐ S (check one)

Patient's Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Guarantor (responsible for minors):_____ Relationship to patient:_____

WORK#_____

Primary Insurance Company: _____

Primary Policy Holder:_____ Relationship to patient:_____

Primary Policy Holder's Date of Birth: _____ Primary Policy Holder's SS#: _____

Secondary Insurance Company: _____

Secondary Policy Holder:_____ Relationship to patient:_____

Secondary Policy Holder's Date of Birth: _____ Secondary Policy Holder's SS#: _____

In case of Emergency, whom should we contact? _____

Relationship to Patient_____

Phone #:_____(Home) and Phone #:_____(work/cell)

Payment is expected at the time of service for charges not covered by your insurance including office visit co-pays and deductibles. High Plains Dermatology Center is not responsible for out-of-network denials or reduced benefit payments. It is the patient's responsibility to verify network benefits. Your signature below indicates that you understand and accept responsibility for the charges not covered by your insurance and authorizes this office to release medical information necessary to process your insurance claim. You authorize payment of medical benefits to High Plains Dermatology Center when a claim is filed on your behalf. The patient is responsible for lab work and pathology billed by the pathologists that are independent form our office. High Plains Dermatology Center charges **$45 for missed appointments** and **appointments cancelled with less that 24 hours notice**.

☐ **I hereby acknowledge receipt of High Plains Dermatology Center's Notice of Privacy Practices.**

_____ _____
Patient (or Responsible Party) Signature Date

Dermatology Medical History

Patient: _____ Date: _____

Are you allergic to any medications: ☐ Yes ☐ No If yes, list:_____

_____

Have you ever had problems with local anesthesia (Lidocaine/Xylocaine)? Yes ☐ No ☐ Any serious reaction? ☐ Yes ☐ No

Do you take **Aspirin, Coumadin (Warfarin), Plavix, Pradaxa** or other **blood thinner**? ☐ No ☐ Yes (Rx) _____

Do you have now, or have you ever had diseases or conditions:

	YES	NO
Pacemaker:	☐	☐
Artificial Heart Valves	☐	☐
Irregular Heartbeat	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Rheumatic heart disease	☐	☐

	YES	NO	
Diabetes	☐	☐	
Thyroid	☐	☐	
Kidney failure/dialysis	☐	☐	
Hepatitis	☐	☐	
If yes, what type?	☐ A	☐ B	☐ C
Artificial joints	☐	☐	
HIV/AIDS	☐	☐	
Convulsions, Epilepsy, Seizures or Fainting	☐	☐	

Skin:

Have you ever had skin cancer?	☐ YES ☐ NO	If yes, what kind? _____
Has anyone in your family had skin cancer?	☐ YES ☐ NO	If yes, what kind? _____
Do you have a history of any specific skin diseases?	☐ YES ☐ NO	If yes, what kind? _____
Do you bleed easily, or have a bleeding disorder?	☐ YES ☐ NO	

List any other diseases or conditions: _____

_____

List surgical procedures you have had in the last 6 months: _____

Social History:

Do you drink alcohol: ☐ YES ☐ NO If YES, how many drinks per day? _____

Do you smoke? ☐ YES ☐ NO If YES, how much? _____

Have you had or have you been exposed to HIV/AIDS or Hepatitis C? ☐ YES ☐ NO

What is your occupation? _____

Who is your **Primary Care Physician** (pedi, family med, internal med)? _____

Women – Menstrual History

Last Menstrual Period: _____ Are you pregnant? YES NO Are you trying to become pregnant? YES NO

If pregnant, OB/GYN physician: _____ weeks gestation? _____ estimated due date? _____

Are you breast feeding? ☐ YES ☐ NO

_____ _____

Signature of Patient / Legal Guardian Date

HIGH PLAINS DERMATOLOGY CENTER

PERSONAL HEALTH INFORMATION RELEASE

If biopsy/lab testing is necessary, may we leave results on your answering machine? Yes or No

If biopsy/lab testing is necessary, may we leave results with another member of your household? Yes or No. If yes, please specify those people below.

Communicating with a patient's family, friends or others involved in your care is an important part of continuing care to our patients. Please list below anyone you would like us to communicate your personal health information with.

Name:_____ Phone #_____

Relationship to you:_____

Name:_____ Phone #_____

Relationship to you:_____

Name:_____ Phone #_____

Relationship to you:_____

SIGNATURE_____DATE_____

HIGH PLAINS DERMATOLOGY OFFICE POLICIES

Insurance
The patient is responsible for providing High Plains Dermatology with the correct insurance information and obtaining any referrals required by there insurance company. Please bring photo identification & current insurance card to every visit.
The patient is responsible for responding promptly to requests from the insurance company to provide any additional information they may require. If this information is not provided and they do not pay us because of the delay, the account will become due and payable in full at that time. Contrary to common understanding, all procedures (e.g. freezing of warts, injections, skin biopsies) are considered surgical procedures by most insurance companies, so the fees for these services may apply to a separate surgical deductible, copayment or coinsurance. Skin tag removal is considered cosmetic and is not covered by insurance.

We accept most major insurance companies including, but not limited to, Medicare, United, BCBS, IMS, Aetna, Humana and City of Amarillo. We only accept some of the Medicare replacement plans. We do not accept CHIPS and Medicaid. Please call the office or check your insurance website to see if we are in-network.

Pathology
We use Cockerell Dermatopathology and Alliance/Coastal Pathology to read all of our biopsy specimens, you will receive a separate bill for those services. Please call: Cockrell 800-309-0000 or Alliance/Coastal 214-420-6348

Payment
All copayments and deductibles are due at the time of the office visit. Any remaining balance after the insurance has paid is the patient's responsibility and is due upon receipt of the bill. If your account has a balance due, please plan to pay that balance before or at the time of an upcoming appointment. Patients without insurance coverage should be prepared to pay their visit balance of the date of the visit. We accept cash, checks, Visa, Mastercard, Discover and American Express.
Our office charges a $30(plus tax) returned check fee. Past due accounts are turned over to a collection agency.
We use New Horizon Billing Service, if you have a question about your bill please call 806-355-9595.

Missed Appointments and Cancellations
For cancellations please contact our office at least 24 hours prior to the scheduled appointment. We reserve the right to charge a $45 fee for late cancellations and missed appointments. A $100 non-refundable deposit is required for elective procedures.

Medical Records
Medical records can be obtained by the patient or sent to another office with completion of a written request. A $25 fee may be charged for these records.

HIPAA
All medical records are protected as required by law. Copies of our privacy policy are available at the office.

Prescriptions
Please bring a list of all medications the patient is taking (including prescription topical creams and over-the-counter creams or medicines) to each visit. If a 3-month supply is required, please inform the physician before they write the prescription. If you need a refill, please contact your pharmacy first and allow 48 hours for all refill requests.

Treatment of Minors
Minor patients must be accompanied by a Parent or Legal Guardian (proper documentation must be presented at time of initial visit) for their initial visit to review treatment options and to consent to the treatment care plan. After minor patient's initial visit, you can discuss with their physician other options for future appointments. If you designate a friend or family member to bring the minor patient after the initial visit, you will need to fill out our Minor Consent Form.

_____Patient Initials

MEDICATION AND OVER THE COUNTER LIST

Patient Name: _____

Preferred pharmacy: _____ Pharmacy Phone #:_____

Date	Medication Name	Strength	Frequency	Unknown	Med. Ass't. Date & Initial

* All meds taken PO unless otherwise specified