

# cole | dermatology

*Medical & Surgical Dermatology*

PLEASE PRINT.

Mr  Ms  Dr NAME \_\_\_\_\_ SEX  M  F

DATE OF BIRTH \_\_\_\_\_ LAST 4 DIGITS SS# \_\_\_\_\_  
(FULL SS# of sponsor if Tricare)

PREFERRED LANGUAGE  English  Other \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PH (\_\_\_\_) \_\_\_\_\_ WORK PH (\_\_\_\_) \_\_\_\_\_ CELL PH (\_\_\_\_) \_\_\_\_\_

PREFERRED CONTACT NUMBER (appointment reminders, biopsy results, etc)  Home  Work  Cell

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  Student  Retired

RACE	ETHNICITY
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other	<input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Hispanic or Latino

How did you hear about us? \_\_\_\_\_

Has any member of your family been treated at Cole Dermatology before?  Yes  No

If yes, name of family member(s) \_\_\_\_\_

Marital Status  Single  Married  Widowed  Divorced  Separated Spouse's Name \_\_\_\_\_

Are you:  Insured (If so, please provide copy of your insurance card(s)).

Self Pay (Please note that payment is due when services are rendered).

Name of Person Responsible for Bill (if patient is a minor) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Responsible Party's Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## CONSENT FOR TREATMENT

I consent to treatment necessary or desirable to the care of me (or my minor), including but not limited to, medicine, performance of procedures and ordering of laboratory or other studies that may be used by the physician or his qualified surrogate.

 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## RELEASE OF MEDICAL INFORMATION

I authorize Cole Dermatology, LLC to release information concerning my (or my minor's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original and assign directly to Cole Dermatology, LLC all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am responsible for all final charges whether or not they are paid by insurance. Regulations pertaining to Medicare assignment of benefits apply. I authorize Cole Dermatology, LLC to communicate my medical diagnoses and treatment plan as necessary to secure payment of benefits and to other physicians involved in my care.

 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the privacy practices of Cole Dermatology, LLC and that I have read (or had the opportunity to read if I so chose) and understand the Notice. This acknowledgement is **requested** per federal law/HIPAA requirement.

 SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

CONTINUED ON BACK 

**PROTECTED HEALTH INFORMATION RELEASE**

I authorize Cole Dermatology, LLC to discuss or release my health information to the person or persons listed below. Examples include (but are not limited to) someone calling on your behalf regarding prescription refills, biopsy results, etc., or our office leaving a message (biopsy results, appointment reminders, etc.) with someone over the phone when you are not available. I understand that it is my responsibility to notify Cole Dermatology, LLC in writing should my desires change.

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Ph (\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Ph (\_\_\_\_\_) \_\_\_\_\_

**DECLINE (Information with not be shared with ANYONE except as permitted/required by law; leave above fields blank and sign below.)**



SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**OFFICE AND FINANCIAL POLICIES**

**PLEASE INITIAL EACH ITEM.**

- \_\_\_ 1. Payment is expected in full by cash, check, money order, or credit/debit card at the time services are rendered. We accept Visa, MasterCard, Discover, and American Express.
- \_\_\_ 2. Any patient 18 years or older will be the responsible party for his/her account. The parent or guardian accompanying a minor child is responsible for any payment due at the time of service. Cole Dermatology, LLC does not mediate divorce or custody agreements.
- \_\_\_ 3. Please understand that as health care providers, our relationship is with you. Your insurance policy is a contract between you and your insurance company; we are not a party in that contract. We accept many insurance plans, but please check with our office for specifics. You are ultimately responsible for checking with your insurance company regarding coverage.
- \_\_\_ 4. In order to correctly file your visit with your insurance company, you may be asked to present your current insurance card at each visit. Without the necessary information, we will be unable to bill your insurance company on your behalf. You are responsible for any and all charges we are unable to bill to your insurance.
- \_\_\_ 5. Costs not covered by your insurance (including deductibles, co-pays, and co-insurance) are payable at the time services are rendered. Any overpayment will be reimbursed to you.
- \_\_\_ 6. Some insurance policies require a primary care referral to see a specialist. While we make every effort to inform you if one is required, it is ultimately your responsibility to ensure a proper referral is obtained prior to your visit.
- \_\_\_ 7. Please be aware that some diagnoses (e.g., skin discoloration and hair loss) may be considered cosmetic or not medically necessary by your insurance carrier. Costs associated with these conditions may not be covered by your policy. It is your responsibility to know your plan.
- \_\_\_ 8. Accounts over 120 days past due are subject to a referral to an outside collection agency. In addition to account balances, the responsible party will be billed for all associated collection and/or attorney's fees.
- \_\_\_ 9. To ensure prompt and efficient patient care, we require 24-hour notice to reschedule or cancel appointments. A reactivation fee up to \$50.00 may be assessed for each missed appointment in order to reschedule if you "no-show" or fail to give 24-hour notice. Patients arriving more than 15 minutes after their appointment time may be asked to reschedule. Habitual no-shows or last-minute appointment changes may result in dismissal from the practice.
- \_\_\_ 10. Unless stated otherwise, specimens biopsied/removed will be sent for pathologic examination. This will incur a pathology fee unrelated to Cole Dermatology, LLC.

I have read and understand the Office and Financial Policies and agree to abide by its contents.



SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FOR MINOR PATIENTS ONLY:** All minors must have a parent or legal guardian present at their initial visit. Minors 15 years of age or younger **MUST** have an authorized adult present for each office visit. Patients 16 or 17 years of age may be seen at follow up visits without an adult if prior consent has been given by the parent/guardian (below).

I, \_\_\_\_\_, am the parent/legal guardian of \_\_\_\_\_. I authorize health care professionals at Cole Dermatology, LLC to provide medical care to my minor child, including, but not limited to, diagnostic examinations and necessary medical treatment (including minor surgical procedures) when they arrive unaccompanied at the office and/or with an authorized adult.

Please list authorized adults below:

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_



SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Please Print

PATIENT HISTORY FORM

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Reason for visit \_\_\_\_\_

**PAST MEDICAL HISTORY** Indicate below any conditions that you either have or have had in the past.

- NONE
- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation (irregular heartbeat)
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD/reflux
- Other: \_\_\_\_\_
- Hearing Loss
- Hepatitis (Hep B, Hep C)
- Hypertension (high blood pressure)
- HIV / AIDS
- Hypercholesterolemia (high cholesterol)
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

**PAST SURGICAL HISTORY** Have you had any of the following?  NONE

- Organ Transplant If so, type: \_\_\_\_\_ year: \_\_\_\_\_
- Heart Valve Replacement If so, year: \_\_\_\_\_
- Joint Replacement(s) If so, which joint(s): \_\_\_\_\_ year: \_\_\_\_\_
- Skin surgery for:  Basal Cell Carcinoma  Squamous Cell Carcinoma  Melanoma
- Other: \_\_\_\_\_

**SKIN DISEASE HISTORY** Have you had any of the following conditions?  NONE

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Eczema
- Other: \_\_\_\_\_
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

Do you wear sunscreen regularly?  Yes  No

If Yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?  Yes  No

Do you have a family history of melanoma?  Yes  No

If Yes, which relative? \_\_\_\_\_

Please Print

**PATIENT HISTORY FORM**

**REVIEW OF SYSTEMS**

- Do you have any problems with bleeding? Yes No  
Do you form keloids or thick scars? Yes No  
Do you have a pacemaker or defibrillator? Yes No

**MEDICATIONS** NONE

Current medications and dosages (including prescribed, over-the-counter, and vitamins/supplements).

---

---

---

---

---

What is your preferred pharmacy? \_\_\_\_\_

**ALLERGIES** NONE

Please list medication allergies that you have, and the resulting reaction (hives, nausea, etc).

---

---

---

---

- Are you allergic to local anesthetic (lidocaine, etc?) Yes No  
Are you allergic to adhesives or bandages? Yes No

**SOCIAL HISTORY**

Do you live Alone with Spouse with Family with Friend Other

SMOKING STATUS Never Smoker Current every day smoker Current some day smoker  
 Former smoker Smoker, current status unknown Unknown if ever smoked

What is your occupation? \_\_\_\_\_

Has anyone in your family been treated at our office before? Yes No If yes, Who? \_\_\_\_\_