INTEGRA DERMATOLOGY

Intake and History Form

Today's Date:___/___/_____

Name: Date of Birth: Gender: M F

Address: City/State: Zip:

Billing Address (if different than above): City/State: Zip:

Phone: □ Home □ Cell Preferred Language: □ English □ Other

Email: Race: □ Decline

Status: □ single □ Married □ Divorced □ Separated □ Widowed Ethnic Group: □ Hispanic/Latino □ Not Hispanic/Latino □ Decline

Occupation and Workplace:

Emergency Contact: Phone: Relation:

Primary Physician: **Physician Referred?** □ No □ Yes by:

Preferred Pharmacy: Location: Phone:

Past Medical History

Select any of the following medical conditions you currently have:

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Bone Marrow Transplant
□ BPH
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Hepatitis
□ Hypertension
□ HIV / AIDS
□ Hypercholesterolemia
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke
□ None
□ Other
_____
_____
_____
_____
_____

Past Surgical History

Have you had any of the following surgeries?

□ Appendectomy
□ Cystectomy
□ Breast Biopsy
□ Lumpectomy R L
□ Mastectomy R L
□ Colon Cancer Resection
□ Diverticulitis
□ Inflammatory Bowel Disease
□ Colostomy
□ Cholecystectomy
□ Gallbladder
□ Coronary Bypass Surgery
□ Heart Transplant
□ Mechanical Valve Replacement
□ PTCA
□ Hip Replacement R L
□ Knee Replacement R L
□ Kidney Biopsy
□ Kidney Stone Removal
□ Kidney Transplant
□ Nephrectomy
□ Hepatectomy
□ Liver Transplant
□ Shunt
□ Endometriosis
□ Ovarian Cancer
□ Ovarian Cyst
□ Tubal Ligation
□ Pancreatectomy
□ Prostate Biopsy
□ Prostate Cancer
□ TURP
□ APR
□ Low Anterior Resection
□ Basal Cell Carcinoma
□ Melanoma
□ Skin Biopsy
□ Squamous Cell Carcinoma
□ Splenectomy
□ Orchietomy
□ Fibroids
□ Uterine Cancer
□ Cervical Cancer
□ Other
_____

Skin Disease History

Have you had any of the following?

□ Acne
□ Actinic Keratosis
□ Asthma
□ Basal Cell Skin Cancer
□ Blistering Sunburns
□ Dry Skin
□ Eczema
□ Flaking or Itchy Scalp
□ Hay Fever / Allergies
□ Melanoma
□ Poison Ivy
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Cancer
□ None
□ Other
_____
_____
Do you wear sunscreen? Y N what SPF? _____
□ Tan in tanning salon? Y N
□ Family History of Melanoma Who? _____
□ Family History of Other Skin Cancer

Family History

Please include only first-degree relatives:

Social History

Smoking Status: □ Current □ Former □ Never **Start Smoking Date:** _____ **Quit Smoking Date:** _____ **Pks Per Day:** _____

Alcohol Intake: □ None □ 1 or less per day □ 1-2 per day □ 3 or more per day Driving Status: □ Drives in the Daytime □ Drives at Night

How often do you exercise? □ Never □ Few days per month □ Few days per week □ Once a day □ Several times a day

What is your caffeine use? □ Never □ Few times a month □ Few times a week □ Once a day □ Several times a day

Pregnant or Planning Pregnancy? □ Yes □ No □ **Pneumonia Vaccination** □ Flu Vaccination

Medications (use back if needed)	**Dosage**	**Frequency**	**Reason**

Allergies

List all allergies and reactions if known:

INTEGRA DERMATOLOGY

Patient Consent Form

Today's Date:___/___/_____

Name: Date of Birth:

I hereby authorize staff of INTEGRA DERMATOLOGY, P.A. to call or leave messages at the following phone numbers:

Home: Cell: Work:

AUTHORIZATION TO DISCUSS MEDICAL RELATED INFORMATION:

This authorization allows Integra Dermatology, P.A. to discuss **ALL ASPECTS** of my protected health information and treatment including but not limited to test, biopsy results, billing information and prescription information with the following individual(s) listed below:

Name: Relationship: Phone:

Name: Relationship: Phone:

INSURANCE INFORMATION:

Primary Insurance: ID#: Group #:

Policyholder Information (if different from patient):

Name: Date of Birth: / / Relationship:

Address:

Secondary Insurance: (if applicable): ID#: Group #:

Policyholder Information (if different from patient):

Name: Date of Birth: / / Relationship:

Address:

□ **NO INSURANCE / SELF PAY *FULL AMOUNT DUE TODAY AT TIME OF VISIT*** signature: _____

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider to examine and treat me. I understand that this could include biopsies, lab tests, destruction treatments, or other diagnostic procedures. These services could be billed separately by different laboratory and pathology companies. I understand that my provider is available to explain the purpose of the treatments and procedures and that I have the right to refuse the recommended treatment.

BILLING AUTHORIZATION: I hereby authorize INTEGRA DERMATOLOGY, P.A. to release requested medical information to my insurance company to collect payment for any charges.

ASSIGNMENT BENEFITS: I hereby request that payment of insurance benefits be made directly to INTEGRA DERMATOLOGY, P.A. on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to the service(s) rendered to myself or my dependent. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

FINANCIAL POLICY: I hereby acknowledge that I have had access to and been able to review the financial policy of INTEGRA DERMATOLOGY, P.A. I know that any co-pay is due at the time of service. I am familiar with INTEGRA DERMATOLOGY, P.A. policies on insurance benefits, claims, referrals, precertification, and lack of insurance. I am also aware of INTEGRA DERMATOLOGY, P.A. policies on finance charges and past due balances.

ELECTRONIC PRESCRIBING: I authorize INTEGRA DERMATOLOGY, P.A. to retrieve my medication history through their e-prescribing system and then import my current medications into my electronic medical record.

PATIENT'S RIGHT TO PRIVACY: I acknowledge I have been made aware of INTEGRA DERMATOLOGY, P.A. and HIPAA's privacy practices. I understand that a copy of INTEGRA DERMATOLOGY, P.A. and HIPAA's privacy practices will be made available to me upon request. I consent to be contacted by INTEGRA DERMATOLOGY, P.A. or other business associates at the physical address, phone numbers, and email address provided.

SIGNATURE: _____ **DATE:** _____

Printed name of person signing (if different from patient): _____

****MEDICARE PATIENTS ONLY:** THIS MEDICARE AUTHORIZATION MUST BE INITIALED IF PATIENT HAS MEDICARE. AUTHORIZATION IS MANDATORY TO ALLOW US TO FILE CHARGES WITH MEDICARE ON THE PATIENTS BEHALF

I request the payment of authorized Medicare benefits be made on my behalf to INTEGRA DERMATOLOGY P.A. for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as non-covered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those services rendered.

INITIAL: _____