Seaside
DERMATOLOGY

Welcome to Seaside Dermatology!

Please complete this form and bring to your appointment with your insurance card and driver's license as well as your medication list if applicable. Please notify us any time you have changes to your medical record including address, phone, or insurance.

If you have an HMO insurance plan, you are responsible for obtaining the proper authorization/referral from your Primary Care Physician. We will reschedule your appointment if we have not received paperwork prior to your appointment.

Name (First, Middle, Last)	Gender □ Male □ Female Other: _____	Date of Birth
Mailing Address		
Seasonal Address		
Email Address		Primary Language □ English □ Spanish Other: _____
Home Phone	Cell Phone	How did you hear about us?
Emergency Contact Name	Emergency Contact Phone #	Preferred Pharmacy
THIS SECTION MUST BE COMPLETED Did a physician refer you to our practice? Yes No	Referring Physician Name: _____	

Health History Form

Past Medical Conditions (please check all that apply)

□ NONE
□ Anxiety disorder
□ Arthritis
□ Asthma
□ Atrial fibrillation
□ Benign prostatic hyperplasia
□ Cerebrovascular accident
□ Chronic obstructive lung disease
□ Coronary arteriosclerosis
□ Depressive disorder
□ Diabetes mellitus
□ Disease caused by COVID 19
□ Elevated blood pressure
□ End stage renal disease
□ Epilepsy
□ Gastroesophageal reflux disease
□ Hypertension
□ Hearing loss
□ Human immunodeficiency virus infection
□ Hypercholesterolemia
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory disease of the liver
□ Leukemia
□ Malignant lymphoma
□ Malignant tumor of lung(s)
□ Malignant tumor of breast
□ Malignant tumor of colon
□ Malignant tumor of prostate
□ Radiation therapy treatment management
□ Transplant of bone marrow

Other: _____

Past Surgeries

□ NONE
□ Abdominoperineal resection
□ Bilateral replacement of knee
□ Biopsy of breast
□ Biopsy of prostate
□ Coronary artery bypass graft
□ Entire transplanted kidney
□ Excision of basal cell carcinoma
□ Excision of melanoma
□ Excision of squamous cell carcinoma
□ Colostomy
□ Tubal ligation
□ Appendectomy
□ Bilateral mastectomy
□ Cholecystectomy
□ Colectomy
□ Liver excision
□ Percutaneous transluminal coronary angio
□ Tissue graft heart valve replacement
□ Total cystectomy
□ Transurethral prostatectomy
□ Hysterectomy
□ Kidney biopsy
□ Low anterior resection of rectum
□ Lumpectomy of breast – L □ R □
□ Mastectomy of breast – L □ R □
□ Mechanical right valve replacement
□ Oophorectomy
□ Pancreatectomy
□ Percutaneous extraction of kidney stone
□ Portosystemic shunt operation
□ Prostatectomy
□ Prosthetic arthroplasty of bilateral hips
□ Splenectomy
□ Liver transplant
□ Total knee replacement
□ Total hip replacement
□ Heart Transplant

Skin Disease History (please check all that apply)

□ NONE

□ Acne

□ Actinic keratosis

□ Basal cell carcinoma

□ Dysplastic nevus of the skin

□ Squamous cell carcinoma

□ Sunburn of second degree

□ Malignant melanoma (date/location)

_____

Other: _____

Do you wear sunscreen?

□ Yes

□ No

SPF? _____

Do you have a family history of melanoma?

□ Yes

□ No

Family Member: _____

Do you tan in a tanning salon?

□ Yes

□ No

Do you smoke?

□ Current Smoker

□ Former Smoker

□ Never Smoked

Please list the medications you currently take:

Medication Name	Dosage (# of mg, oz, etc)	Route (oral, injection, topical)	Frequency

Medication Allergies (please list medication and reaction that you experience): _____

_____

_____

_____

_____

_____

Review of Systems (please check YES or NO):

Symptoms	
Fever or Chills	□ Yes □ No
Unintentional weight loss	□ Yes □ No
Night sweats	□ Yes □ No
Enlarged lymph nodes	□ Yes □ No
Problems with bleeding	□ Yes □ No
Rash	□ Yes □ No
New or changing mole(s)	□ Yes □ No

Alerts (please check YES or NO):

Pacemaker	□ Yes □ No
Defibrillator	□ Yes □ No
Pre-medications prior to procedures	□ Yes □ No
Artificial heart valve	□ Yes □ No
Allergy to lidocaine	□ Yes □ No
Rapid heartbeat with epinephrine	□ Yes □ No
Allergy to adhesive	□ Yes □ No
Allergy to topical antibiotic ointments	□ Yes □ No
Blood thinners	□ Yes □ No
MRSA staph infection	□ Yes □ No
Pregnancy or planning one	□ Yes □ No
Breastfeeding	□ Yes □ No
Hospice	□ Yes □ No

Please list any other pertinent health information:

_____
_____
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Seaside Dermatology - PHI/HIPAA Consent

Patient Consent for Release of Personal Protected Health Information

I hereby give consent for Seaside Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Seaside Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, and prescriptions. I assign payment of medical benefits to the physician. Your signature below authorizes the release of your medical information and payment as listed above and signifies your willingness to comply with our financial policy.

WITH THIS CONSENT, Seaside Dermatology, MAY DISCUSS TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS WITH THE FOLLOWING PERSON(S):

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBERS, AND RELATION TO YOU

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

☐ **NO ONE OTHER THAN MYSELF IS PERMITTED TO HAVE MY INFORMATION**

May we call your home/cell phone and leave a detailed message on your voicemail?

□ **Yes**

□ **No**

In the event you are unable to make medical decisions for yourself, who may we contact on your behalf?

Name: _____ Phone: _____

I understand that **Seaside Dermatology** cannot share my health information with family members, including my spouse, child, caregiver or other person unless they are listed above. I also understand that this release of information will remain in effect unless I revoke my consent in writing, except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Seaside Dermatology** may decline to provide treatment for me.

By signing this form, I am consenting to **Seaside Dermatology's** use and disclosure of my PHI to carry out TPO

_____	_____	_____
Signature of Patient or Legal Guardian	**Print name of Patient or Legal Guardian**	**DOB**

Payment Policy

We ask that you read and sign the following form to acknowledge your financial responsibility for the medical services provided here. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage; including referrals, authorizations, covered benefits, etc.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. All outstanding balances will be collected prior to your visit. We accept payment via cash, check, debit/credit cards, and Care Credit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please note that you may be billed separately for Laboratory analysis if we send specimens to an external lab.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Failure to settle your balance could result in further collection efforts.
8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. There is a $50 fee for missed appointments and cancellations less than 24 hours in advance. These charges will be your responsibility and payment will be required prior to scheduling a future appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____	_____
Signature of Patient or Legal Guardian	**Print name of Patient or Legal Guardian**	**Date**