

**Patient Information**

*Please Complete All Sections*

Name (Last, First, M.I.) \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_

Home Address (street, city, state, zip) \_\_\_\_\_

2<sup>nd</sup> Mailing address (street, city, state, zip) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

**Indicate your communication preference to leave message/contact you (please circle one)**

Home Phone   Cell Phone   Work Phone   US Mail   Is it okay to leave a message at that number?   Yes   No

**Responsible Party, if different from patient**

Name (Last, First, M.I.) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_

Mailing Address (street, city, state, zip) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

**In Case of Emergency**

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_

**Primary Insurance Information**

*Card must be presented at time of visit*

Primary Insurance \_\_\_\_\_

Policy # \_\_\_\_\_

Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_/\_\_\_/\_\_\_

**Secondary Insurance Information**

*Card must be presented at time of visit*

Secondary Insurance \_\_\_\_\_

Policy # \_\_\_\_\_

Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_/\_\_\_/\_\_\_

**Employment Information**

Primary Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

**Employment Information**

Other Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

**Release of Information and Assignment of Benefits**

I authorize the release of medical information to my primary care, referring physician or consultants. I also authorize payment of medical benefits to the physician and release of medical information to my insurance company(s) as necessary to process insurance claims, insurance applications and prescriptions.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If your primary insurance is a Medicare plan AND you have a secondary insurance to supplement this plan, we are required to have a separate signature for the secondary plan. Please sign below.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Consent for Medical Photography**

I consent for medical photographs and videos to be made of me (or my child or person for whom I am legal guardian), for purposes of:

- Patient identification
- Improved care through digital image monitoring of skin lesions, conditions and treatment sites
- Medical teaching and education (identifying information will be withheld)

I understand that the photographs and videos become part of my medical record and as such are subject to the "Release of Information and Assignment of Benefits" consent signed previously. Refusal to consent will in no way affect the medical care I will receive.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**HIPAA Notice of Privacy Practices**

Please list below any person(s) you authorize us to release your medical information to or discuss your medical condition(s) with, upon their request:

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Signature below is acknowledgement that you have received our Notice of Privacy Practices.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **Payment Policy**

Payment is required for all services at the time rendered unless you are in a payment or insurance plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. Seaport Dermatology does not have independent knowledge of its patients' insurance coverage and therefore is not responsible for informing any patient of his or her insurance coverage, deductibles, co-payments, non-covered or excluded services, or any other aspect of his or her insurance. Please note that the patient is responsible for all charges not paid by his or her insurance company. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, we reserve the right to pre-verify your coverage and ask you to pay any un-met deductible, co-payments and fees for non-covered services. If you need to cancel or reschedule an appointment, you must do so before 9:00 a.m. the day before the scheduled appointment or we reserve the right to charge a late cancellation fee which would not be covered by insurance.

It is our policy to bill you based on a specific date of service and send only two statements for each date of service. The first statement will be sent to you once insurance payments have been received in full for that date of service. Receipt of your payment in full will clear the remaining balance for that date of service. You may still have claims that are being processed for other dates of service.

The second statement is sent 30 days after the first. If no payment is received on your account during the 60-day period following the date of the first statement we will turn your accounts over to collections without additional notice. We feel that two months is a reasonable amount of time to make payments on your account.

In the event my account is referred to an attorney or collection agency for collection, I agree to pay for processing or convenience fees, if required, as a cost of collection of my account. I understand that such fees would only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency.

Your signature below signifies your understanding and willingness to comply with these policies.

Patient or Responsible Party Signature

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Social History:** (please circle all that apply)

**Cigarette Smoking:**

**Alcohol Use:**

- Currently Smokes
- Has smoked in the past
- Never smoked
- Former Smoker

- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Other \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: (circle) Hispanic/NonHispanic

Living Situation: (circle)

- Lives Alone
- Lives with Spouse
- Lives with Adult Child
- Lives with Young Child
- Lives with Roommate
- Lives with Domestic Partner

Type of Residence: (circle one)

- Skilled Nursing Facility
- Assisted Living
- House – multi level
- House – single level
- Apartment/Condo
- Town House
- Trailer
- Hotel/Motel

Current Marital Status: (circle one)

- Married
- Never Married
- Legally Separated
- Divorced
- Annulled
- Widowed
- Domestic Partner

Occupation: \_\_\_\_\_

**Name of Preferred Pharmacy:** \_\_\_\_\_

Address/Location: \_\_\_\_\_

**Prescription History Consent:** (please circle one) Yes No Prescriber Only

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Primary Care Physician** \_\_\_\_\_

**Date of Last Visit** \_\_\_\_\_

**Referring Physician** \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Names of any Additional Physicians who are currently treating you:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:** (please circle all that apply)

- |                         |                         |                     |
|-------------------------|-------------------------|---------------------|
| Anxiety                 | Depression              | Thyroid Problems    |
| Arthritis               | Diabetes                | Leukemia            |
| Asthma                  | End Stage Renal Disease | Lung Cancer         |
| Atrial fibrillation     | GERD                    | Lymphoma            |
| Bone Marrow Transplant  | Heart Failure           | Prostate Cancer     |
| Breast Cancer           | Hearing Loss            | Radiation Treatment |
| Colon Cancer            | Hepatitis               | Seizures            |
| COPD                    | High Blood pressure     | Stroke              |
| Coronary Artery Disease | HIV/AIDS                | NONE                |
|                         | High Cholesterol        |                     |

Other: \_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History:** (please circle all that apply)

- |   |  |
|---|--|
| Appendix Removed  | Kidney Biopsy (Nephrectomy)                |
| Bladder Removed   | Kidney Removed (Right, Left)               |
| Mastectomy (Right, Left, Bilateral)                         | Kidney Stone Removal                       |
| Lumpectomy (Right, Left, Bilateral)                         | Kidney Transplant                          |
| Breast Biopsy (Right, Left, Bilateral)                      | Ovaries Removed: Endometriosis             |
| Breast Reduction  | Ovaries Removed: Cyst                      |
| Breast Implants   | Ovaries Removed: Ovarian Cancer            |
| Colectomy: Colon Cancer Resection                           | Prostate Removed: Prostate Cancer          |
| Colectomy: Diverticulitis                                   | Prostate Biopsy                            |
| Colectomy: IBD  | TURP (Prostate Removal)                    |
| Gallbladder Removed   | Spleen Removed                             |
| Coronary Artery Bypass                                      | Testicles Removed (Right, Left, Bilateral) |
| Mechanical Valve Replacement                                | Hysterectomy                               |
| Biological Valve Replacement                                | Hysterectomy: Uterine Cancer               |
| Heart Transplant  | NONE                                       |
| Joint Replacement, Knee (Right, Left, Bilateral) Date _____ | Other: _____                               |
| Joint Replacement, Hip (Right, Left, Bilateral) Date _____  | _____                                      |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Skin Disease History:** (please circle all that apply)

- |                        |                        |                         |
|------------------------|------------------------|-------------------------|
| Acne                   | Dry Skin               | Poison Ivy              |
| Actinic Keratosis      | Eczema                 | Precancerous Moles      |
| Asthma                 | Flaking or Itchy Scalp | Psoriasis               |
| Basal Cell Skin Cancer | Hay Fever/Allergies    | Squamous Cell Carcinoma |
| Blistering Sunburns    | Melanoma               | NONE                    |

Other: \_\_\_\_\_

Do you wear Sunscreen? 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(s)? \_\_\_\_\_

Have you been vaccinated for the flu season?	This season	Yes	No
	Last season	Yes	No

Have you ever received the pneumonia vaccine? Yes No

**Medications:** (Please enter all current medications or provide separate list)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:** (Please enter all allergies)  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Medical History:** (Only first degree relatives)  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have an Advance Care Plan/Living Will? Yes No

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Review of Systems:** Are you currently experiencing any of the following?  
(Please check yes or no for the following)

Symptoms	Yes	No
Hay fever		
Chest pain		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Itching		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough		
Wheezing		
Anxiety		
Depression		

Other symptoms: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>ALERTS</b>	YES	NO
*****COPD***** (chronic obstructive pulmonary disease)		
*****Heart Failure*****		
*****Diabetes*****		
*****CAD***** (coronary artery disease)		
history of melanoma		
MRSA (Methicillin-resistant Staphylococcus aureus)		
history of infection after surgery		
immunosuppression		
Hibiclens allergy (surgical soap)		
adhesive allergy		
allergy to cyanoacrylate skin adhesive		
latex allergy		
allergy to topical antibiotic ointments		
lidocaine allergy		
sulfite allergy (NO EPI in local anesthetic)		
premedication required prior to procedures		
internal defibrillator		
artificial heart valve		
pacemaker		
rapid heartbeat with epinephrine		
pregnant or planning a pregnancy		
blood thinners		
aspirin		
blood thinners (non-aspirin)		
problems with bleeding		
prosthetic joint within past two years		
Marcaine required for local anesthesia		
shortness of breath		
Zika Virus Risk: Travel or Contact in the last 21 days		
Other (specify)		