SEAPORT DERMATOLOGY
MOHS SURGERY CENTER

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) _____

2nd 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:

_____

_____

_____

_____

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. It is the patient's responsibility to obtain any HMO required referral from a Primary Care Physician and to provide us with the most recently issued insurance card. 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 polices.

Patient or Responsible Party Signature

_____Date: ___/_____/_____

Patient Name: _____ DOB: _____

Social History: (please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

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

How many times in the past year have you had 5 or more drinks in a day for men or 4 or more drinks in a day for women. _____

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
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Heart Failure
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other:_____

_____

Past Surgical History: (please circle all that apply)

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

_____

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: _____

ALERTS	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)		

This letter has been prepared for you to help you better understand the complexities of medical insurance; we understand how extremely confusing it can be.

To begin, we would like to highlight a MISCONCEPTION. Medical insurance was not designed to pay for all medical care. Most contracts have limits and/or varying degrees of co-payments, co-insurance and deductibles.

All levels of payment by insurance companies, including allowable fees, usual, customary and reasonable charges, are governed by multiple factors including geographic location. They have nothing to do with the actual charges. Though our staff is very knowledgeable about medical insurance, the insurance industry is a conglomeration of companies. Each company has its' own set of policies and each policy has varying benefits and exclusion riders. Many plans require your Primary Care Physician to notify your insurance company if you are referred to a specialist. This results in thousands of different payment outcomes for the same treatment. Seaport Dermatology has thousands of patients. With this payment system, it is impossible for our staff to be able to anticipate what your insurance payment outcome will be. And, we are unable to call insurance companies for every person who has a question about their coverage.

Your contract is between you and your insurance company. We encourage you to know your benefits. You can do this by asking for a Schedule of Benefits from your insurance broker, human resource department or your insurance company. You can also sign up for on line assistance as most insurance companies have their own website. Or, you can simply call and speak with a representative.

We are happy to assist you with the information we have available to us. We ask that you understand our limitations when it concerns information specific to your policy.