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: (____) _____

***Copies of Identification and Insurance Cards must be presented during initial visit and for any insurance changes *If patient is not subscriber please list subscribers name and date of birth here: _____**

In Case of Emergency

Name _____

Relationship to Patient _____Address _____

Home Phone (___) _____Other Phone (___) _____

Name of Preferred Pharmacy/Address and location:

_____

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

*We electronically prescribe medications. This is to ensure there are no medication interactions.

_____ _____

Signature Date

Patient Name:_____DOB:_____

Social History: (please circle all that apply)

Cigarette Smoking:
- Currently Smokes
- 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 2 or more drinks in a day? ____

Preferred Language: _____

Race: _____ Ethnicity: (circle) Hispanic/NonHispanic

Current Marital Status: (circle one)
Married Never Married Legally Separated Divorced Annulled Widowed
Domestic Partner

Occupation: _____

Primary Care Physician _____Date of Last Visit_____

Referring Physician_____

Names of any Additional Physicians who are currently treating you:

_____

_____

_____

How did you hear about us?

Physician Referral ____ Online Newspaper Ad ____ Newspaper Ad ____

Magazine Ad ____ Facebook ____ Instagram ____ Friend or Family Member ____

Other _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for putting your trust in Seaport Dermatology.

Our financial policy does require we collect copays and deductibles at the time of service. We do accept assignment of benefits for most major insurance policies. Please understand that your account must be kept current throughout treatment. The following is our financial policy which we require you to read, agree to, and sign before any treatment.

Payment options:
~CASH/ Check
~Visa, MasterCard, American Express, and Discover
~MOST MAJOR INSURANCE PPO PLANS

1. You are responsible for checking network status, obtaining any necessary HMO plan referrals and notifying us of any changes.
2. Any insurance balances are due when the claim is completed by the insurance company.
3. Please understand that we accept insurance as a courtesy however, the insurance is an agreement between YOU and THEM and you are responsible for any balances.

PAST DUE ACCOUNTS
Accounts without acceptable payment for 30 days will be considered past due. A billing charge may be added to your account in addition to the original account balance.

COLLECTIONS
Accounts without acceptable payment for 60 days will incur a collection fee of 10% in addition to your current balance. At 90 days, your account will be turned over to our collection agency. You will be responsible for any cost associated with the collection of your balance.

CANCELLATIONS
A minimum of 24 hours is required for any cancellations. We reserve the right to charge you a $50 cancellation fee or NO-SHOW fee if adequate notice is not given for your reserved appointment.

Date_____

Patient Name_____Signature_____

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:___/____/____

Patient Name: _____ DOB: _____

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	Precancerous Moles
Actinic Keratosis	Eczema	Psoriasis
Asthma	Flaking or Itchy Scalp	Squamous Cell Carcinoma
Basal Cell Skin Cancer	Hay Fever/Allergies	NONE
Blistering Sunburns	*Melanoma	

*History of Melanoma will require a pathology report or confirmation from PCP

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)? _____

Family Medical History (first degree relatives only)
_____
_____
_____
_____

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes No

Do you have a 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)		
*****CHF***** (congestive heart failure)		
Artificial heart valve		
Pacemaker		
Internal defibrillator		
Rapid heartbeat with epinephrine		
Shortness of breath		
MRSA (Methicillin-resistant Staphylococcus aureus)		
History of infection after surgery		
Immunosuppression		
Hibiclens allergy (surgical soap)		
Adhesive allergy		
Allergy to surgical skin adhesive		
Latex allergy		
Allergy to topical antibiotic ointments		
Lidocaine allergy		
Sulfite allergy (NO EPI in local anesthetic)		
Premedication required prior to procedures		
Pregnant or planning a pregnancy		
aspirin		
Blood thinners (non-aspirin)		
Problems with bleeding		
Marcaine required for local anesthesia		
Other (specify)		

Patient Name: _____DOB:_____

List of Current Medications:

List of Vitamins and Supplements:

Allergies (including drug allergies):

PLEASE READ

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.