DERMATOLOGY SURGERY CENTER

Scott L. Beals, DO, FAAD
www.dermsurgctr.com
Fax: 850- 897-7547

4566 Hwy 20 E, Suite 101
Niceville, FL 32578
(850) 897-7546

YEARLY PATIENT UPDATE INFORMATION

First Name: _____ Last: _____ M.I.: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Social Security Number: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (____) _____

E-Mail Address: _____

Emergency Contact Name: _____ Phone: (____) _____

Guarantor's Name (if patient is a minor) _____ Relationship: _____

Can we leave a detailed voicemail message? ☐ Yes ☐ No

Preferred Pharmacy: _____

INSURANCE INFORMATION:

Primary Insurance

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Insurance Company: _____ Policy ID/Member ID #: _____

Primary Policy Holder(If not self):

Primary Insured Name: _____ Gender: M ( ) F ( ) Primary Insured's Date of Birth: ___/___/___

Secondary Insurance

Relationship to Patient: ( ) Self ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Insurance Company: _____ Policy ID/Member ID #: _____

Primary Policy Holder(If not self):

Primary Insured Name: _____ Gender: M ( ) F ( ) Primary Insured's Date of Birth: ___/___/___

Tricare/Tricare for Life:

Sponsor's Date of Birth: ____/____/____ Social Security Number: _____-_____-_____Status: _____

The contents of DERMATOLOGY SURGERY CENTER PRACTICE POLICIES have been fully reviewed by me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of that form.
(A copy of DERMATOLOGY SURGERY CENTER PRACTICE POLICIES or HIPAA PRIVACY GUIDELINES is available for you to keep upon request.)

_____
Printed Patient (and Authorized Representative) Name

_____ _____
Signature of Patient or Authorized Representative Date

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HISTORY AND INTAKE FORM

Name: _____ **DOB:** _____/_____/_____
Language: English Other:_____ **Gender: M F Race:** _____

Preferred Pharmacy:_____**Pharmacy Phone:**_____

Pharmacy Address:_____

Primary Care Provider & Phone:_____

Past Medical History: (Please circle all that apply)

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

Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Kidney Biopsy
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
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within the last 2 years	None

Other: _____

_____

(Please continue on the next page)

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Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/ Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	None

Other: _____

Do you wear Sunscreen? Yes No What SPF? _____

Do you have a family history of melanoma? Yes No If yes, which relative(s)? _____

Do you tan in a tanning salon? Yes No

Medications: (Please list all current medications, strength)

_____

_____

_____

Allergies: _____

Social History: (Please circle all that apply)

Current Smoker Former Smoker Never Smoked Type of Tobacco Used_____

What is your current occupation? _____

Review of Systems: Are you currently experiencing any of the following? (please circle all that apply)

Abdominal Pain	Changing Mole	Hay Fever	Seizures
Anxiety	Chest Pain	Joint Aches	Shortness of Breath
Bleeding Problems	Cough	Muscle Weakness	Sore Throat
Bloody Stool	Depression	Neck Stiffness	Thyroid Problems
Bloody Urine	Fever or Chills	Night Sweats	Unintentional Weight Loss
Blurry Vision	Headaches	Rash	Wheezing

Other Symptoms: _____

Surgical Precautions: (Please write Y for Yes or N for No in the blanks below)

Have you ever had difficulty stopping bleeding? _____
Do you require antibiotics prior to a surgical procedure? _____
Have you had an artificial joint replacement? _____
If yes, when and what body locations? _____
Have you had an artificial heart valve? _____
Do you have a pacemaker? _____
Do you have a defibrillator? _____
Are you pregnant or currently trying to get pregnant? _____

Reason for visit: _____

_____

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Patient Responsibility Notification

Please Initial Each Statement

Dermatology Surgery Center strives to offer the highest quality of care to our patients. Due to the numerous changes in Healthcare during this present time, we are informed by insurance companies that no benefits are guaranteed. In order to provide quality care to our patients, we file their insurance as a courtesy, but the following procedures must be in place in order to do so. Please INITIAL next to each statement, then sign and date below, to acknowledge that you have read and understand your patient responsibility. Thank you!

1. **Appointment time:** Arrive 15 minutes prior to your appointment. _____
2. **Patient is responsible for confirming Dermatology Center is on their Insurance Provider List.**
3. **Co-payment, Coinsurance and Deductibles:** Must be paid at time of service. _____
4. **Patient's with No insurance or Out of Network benefits are responsible for full payment of services the day services are rendered.**
5. **Delayed payment:** If your outstanding balance is over 60 days past due, then it is your responsibility to contact your carrier to assess the reason for delay. _____
6. **Outstanding bill:** If your insurance carrier does not reconcile complete payment by 90 days, then the remaining balance is your responsibility. _____
7. **Same day cancellation or No show appointment:** Unless related to an emergency, this will result in an unfilled appointment. There is a $50 fee for Office Visit or $200 fee for Surgical or Cosmetics visits, if you fail to provide 24 hour notice of cancellation or reschedule. _____
8. **Prescription Refills:** Please contact our office directly for prescription refills. No refill requests will be accepted by the pharmacy that sends us a fax. Allow 3 to 5 business days for all refill requests to be processed. _____
9. **Communication:** I grant permission for Dermatology Surgery Center to communicate via phone, voicemail, text or email in regard to my health information, care, and appointments. _____

ACKNOWLEDGEMENT OF FINANCIAL AND PATIENT CARE POLICIES

SIGNATURE REQUIRED TO BE SEEN

I understand that insurance coverage IS NOT A GUARANTEE of payment for any services claimed by myself or Dermatology Surgery Center. Further I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES incurred, regardless of insurance coverage or payment of copays or deductibles due and collected at time of service. I understand that if I do not provide all required identification information for insurance claims filing to Dermatology Surgery Center, and insurance fails to pay, I will be held responsible for total costs of services as well as administration fees to process that claim.

By signing below, I acknowledge that I have read the Dermatology Surgery Center Financial and Patient Care Policies. I certify that I understand these Policies and will comply with them.

_____	_____	_____
Patient Name (Please Print)	**Patient/ Guardian Signature**	**Date**

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Authorization to Release Protected Health Information

In accordance with HIPAA regulations, we will not share your information with anyone without your permission. This form is to authorize the release or use of your individually identifiable medical health information (protected health information or PHI) by Dermatology Surgery Center and staff to carry out treatment, payment, or health care operations. If you would like your information to be shared with a friend, family member or caregiver; please read, and complete the form below.

You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do makes changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

I hereby authorize Dermatology Surgery Center to use and/or disclose Protected Health Information (PHI) about myself via phone, work number, text, email, Patient Portal or in person to the contact(s) listed below:

NAME: _____ PHONE: _____ RELATION: _____

NAME: _____ PHONE: _____ RELATION: _____

NAME: _____ PHONE: _____ RELATION: _____

- I would like the above-named person(s) to pick up medical items, including prescriptions, from the office if I am unable to: YES _____ NO _____
- This authorization permits the practice to use and/or disclose the following identifiable health information about me:
  - All medical documentations or care needs YES _____ NO _____
  - In the event of emergency only YES _____ NO _____
  - Other
    If other, specifically describe the information to be used or disclosed; such as specific date(s) of service or level of detail to be released:
    _____
    _____

Patient Acknowledgement

By signing this form below, I authorize Dermatology Surgery Center and its staff to release my PHI (Protected Health Information) to the above-mentioned contact(s) via phone, work number, text, email, Patient Portal or in person:

_____ _____

Patient/Guardian Signature

Patient Name (please print)*
***If parent or guardian is signing for minors, Please print the minor's name.**

_____

Date

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Credit Card Authorization Form

All copays, coinsurances and deductibles paid at time of service are only estimates based on the rates provided by your insurance carrier. We do our best to collect as close as possible but sometimes insurance carriers do not cover all costs of services. To ensure you only pay the amounts required by your insurance plan, we will be happy to charge your credit card when the exact amount is provided by your insurance company after claims are processed.

Your credit card information will be kept confidential and secure. Charges to your credit card will only be made after the insurance company pays its portion. We will first mail a statement for any amount not covered by your insurance, to give you the opportunity to pay with our many other payment methods before contacting you to charge your card for any balances due.

Please complete the form below:

I authorize Dermatology Surgery Center to charge the portion of my bill that is my responsibility to the following credit card:

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Credit Card Type: ❒ VISA ❒ MasterCard ❒ AMX ❒ Discover

Credit Card Number _____Expiration Date _____

CVS Code _____

Cardholder Name _____

Cardholder Signature _____

Billing Address _____

City _____ State_____ Zip _____