PATIENT INTAKE FORM

PATIENT INFORMATION

Patient's Full Name: ______________________________ **Date of Birth:** ______________

Address: ______________________________ **City, State, Zip:** ______________________

☐ **Home Phone Number:** ____________________ ☐ **Cell Phone Number:** ________________________

Email Address: ______________________________ **Marital Status:** ☐Single ☐ Married ☐Divorced ☐Widowed

Identity: ☐Male ☐Female ☐Transgender **Preferred Language:** ☐English ☐Spanish ☐ Other: ☐

Race & Ethnicity: ☐Native American ☐White ☐ Black ☐ Asian ☐Hispanic or Latino ☐ Other: _______________

How did you hear about us: Check all that apply

☐Referring Doctor ☐Newspaper ☐ Website-Internet ☐Insurance Company ☐ Friend/Family ☐ TV AD

☐Billboard ☐Walk In ☐Social Media ☐Radio ☐Direct Mail ☐Other: _______________

If your PCP referred you, please list their name: ☐

INSURANCE INFORMATION

Subscribers Full Name: ______________________________ **Name of Insurance:** ____________________

Subscribers DOB: ________________________ **Relationship to Patient:** ☐Self ☐ Child ☐Spouse ☐ Other

Policy #: ______________________________ Group #: ______________________________

Secondary Insurance Name: ________________________ Subscribers Name: ________________________

RESPONSIBLE PARTY *(if patient is not financially responsible for account)*

Responsible Party Full Name: ______________________________ DOB: ____________________

Address: ______________________________ City, State, Zip: ________________________

Phone: ______________________________ Relationship to Patient: ☐ Self ☐Child ☐Spouse ☐Other

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PATIENT INTAKE FORM

MEDICAL INFORMATION

Primary Care Provider: ______________________________ **Phone Number:**________________

Facility Name:____

Would you like us to send a letter to your PCP regarding your visit? Yes ☐ No ☐

Preferred Pharmacy: ______________________________**Phone Number:** ________________

Address: ____________________________________ City, State, Zip:____________________

Preferred Laboratory for Bloodwork/Cultures: ____________________________

Medical History: Check all that apply

☐ Anxiety Disorder ☐ Arthritis ☐ Asthma

☐ Atrial Fibrillation ☐ COPD ☐ Coronary Arteriosclerosis

☐ Diabetes ☐ Depression ☐ Elevated Blood Pressure

☐ End-Stage Renal Disease ☐ Epilepsy ☐ GERD

☐ Hearing Loss ☐ HIV ☐ Hyperthyroidism

☐ Hypothyroidism ☐ Hypercholesterolemia ☐ Liver Disease

☐ Prostatic Hyperplasia ☐ Radiation Therapy ☐ Stroke

Past Surgeries	Year

Skin Disease History: Check all that apply

☐ None ☐ Hay Fever

☐ Acne ☐ Malignant Melanoma

☐ Actinic Keratosis ☐ Psoriasis

☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma

☐ Contact Dermatitis ☐ Sunburn- second/third degree

☐ Dysplastic Nevus ☐ Rosacea

☐ Asthma ☐ Other: ________________

DERMATOLOGY PARTNERS

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Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? ____________ **Do you tan in a tanning salon?** ☐ Yes ☐ No

Medication Ex. Aspirin	**Dosage** 81mg	**Frequency** Daily

Allergies Ex: Penicillin	**Reaction** Rash

Do you have a family history of Melanoma? ☐ Yes ☐ No If Yes, list family member: ____________________________

Social History: Check all that apply

Smoking Status: ☐ Never ☐ Former ☐ Current

Alcohol Use: ☐ None ☐ Social ☐ Daily

Patients 65 and older: Check all that apply

Do you have a Healthcare Proxy: ☐ Yes ☐ No

Reason for Today's Visit:

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Operations

Name:___________________________________Date of Birth:________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand, and may request the Notice of Information Practices which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

*I give permission for Dermatology Partners staff to leave information regarding my medical condition(s) on my home/cell phone voicemail/answering machine: ☐ Yes ☐ No

*I give permission for Dermatology Partners staff to discuss all health information with the following person(s) which includes (demographic information, medical histories, biopsy results, insurance information and office visits):

Self Only : ☐

Name:______________________________Relationship:_______________________________

Phone number: (______________)___________________________

Name:______________________________Relationship:_______________________________

Phone number: (______________)___________________________

The people listed above are also my emergency contacts: ○ Yes ○ No

***Signature of Patient/Legal Guardian:** ____________________ **Date:** __________

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Dermatology Partners (DP) as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility.

By signing below and/or by receiving medical services from Dermatology Partners, you agree:

- You acknowledge and agree to the FINANCIAL POLICIES of Dermatology Partners listed below. These policies may be changed from time to time by DP, without notice. If there is any conflict between the FINANCIAL POLICIES and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, the FINANCIAL POLICES shall control.
- You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.
- You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (a) your health plan requires a referral by a Primary Care Physician (PCP) before receiving services at DP, and you have not obtained such a referral; (b) you received services in excess to the number of approved visits on referral; (c) your health plan coverage has lapsed or expired at the time you receive services at DP. You are responsible to know if your insurance is in network with the provider/group you are being treated by. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider.
- You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file in order for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient.
- All patients scheduling or checking in for an appointment will be required to place a credit card on file to cover co-pays, patient balances and deductibles. After the visit, when charges remitted to a patient’s insurance are responded to, any patient balance identified by the carrier will be billed to the credit card on file. Exemptions from this policy include patients with a primary or secondary Medicaid insurance.
- Effective 12/1/2024, Dermatology Partners no longer provides paper billing statements. Billing notifications will continue to be transmitted electronically through both text and e-mail, and you will continue to have access to our convenient online portal to view current and past statements.
- You acknowledge that Dermatology Partners reserves the right to discharge you from our services if deemed necessary by our clinical and senior leadership team.

This document is for informational and financial planning purposes and last updated May 2025. Please ensure that all information provided is accurate and up-to-date. For any questions or concerns regarding the contents of this document or your account, please contact our office

***Signature of Patient/Responsible Party** ______________________

Date: __________

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