NEW PATIENT INFORMATION

Name ____Today's Date_________________
Street Address ____
City _______________________________ State _____________ Zip Code __________________
Home Phone (_____)____________________ Work (______)______________________________
Cell Phone (_____)______________________SS#______________________________________
Date of Birth _________________________Age_______________________ Sex______________
Referred By____
Pharmacy Name & Address: ____
Email Address____

Parent / Guardian / Spouse Information

Name ____ SS # ________________________
Street Address ____
Home Phone (______)_____________________ Work Phone (_______)____________________
Employer____
Employer Address ____
Next of Kin ____
Address ____
Phone (_______)______________________

PRIMARY INSURANCE TO FILE

Insured's Name ___________________________________ Relationship ____________________
Insured's SS # or ID # ____________________________ Insured Date of Birth ______________
Insurance Company Name ____
Insurance Company Address ____

PRIMARY PHYSICIAN INFORMATION

Primary Care Physician ____
Primary Address ____
Primary Care Phone Number (______)_________________________________

Medical History

Circle "Yes" or "No"

1. DO YOU OR ANY MEMBER OF YOUR FAMILY HAVE? (SPECIFY WHO)

Asthma ……………………………………………………………………………………YES NO
Hay Fever …………………………………………………………………………………YES NO
Eczema ……………………………………………………………………………………YES NO
Hives ………………………………………………………………………………………YES NO
Psoriasis …………………………………………………………………………………YES NO
Hair or Nail Problem ……………………………………………………………………YES NO
Cold Sores, Fever Blisters ………………………………………………………………YES NO
Skin Cancer ………………………………………………………………………………YES NO
Diabetes …………………………………………………………………………………YES NO
Bleeding Problems ………………………………………………………………………YES NO
Other skin conditions (specify) …………………………………………………………YES NO

2. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?

Heart Disease (Rheumatic Fever, Pacemaker, etc.) ………………………… YES NO
Liver Disease (Hepatitis, etc) …………………………………………………… YES NO
Lung Disease (Tuberculosis, etc.) ……………………………………………… YES NO

Condition		
Duodenal or Peptic Ulcer	YES	NO
Other Intestinal Disease (Colitis, etc.)	YES	NO
Kidney Disease	YES	NO
High Blood Pressure	YES	NO
Blood or Lymph Disorders	YES	NO
Eye Disease (Glaucoma, Cataracts, etc.)	YES	NO
Arthritis	YES	NO
Stroke	YES	NO
Cancer	YES	NO
Thrombophlebitis	YES	NO
Venereal Disease	YES	NO
Problems with sunburn	YES	NO
Problems with hands in cold water	YES	NO
Frequent infections (skin or other)	YES	NO
Excess bleeding when cut	YES	NO
Poor wound healing; overgrown scars or keloids	YES	NO
Skin x-ray or grenz ray treatments	YES	NO
A growth which changed color or size, bleeds, hurts, itches	YES	NO
Any raised growth present since birth	YES	NO

3. HAVE YOU EVER HAD A REACTION TO ANY OF THE FOLLOWING?

Item		
Novocain or other local anesthetics	YES	NO
Penicillin or Sulfa Drugs	YES	NO
"Mycin" or other antibiotics	YES	NO
Topical Preparations (Neosporin, etc.)	YES	NO
Adhesive Tape	YES	NO
Food	YES	NO
Cosmetics	YES	NO
Others (please specify)	YES	NO

4. TO BE COMPLETED BY ALL WOMEN.

Question		
Have you ever had vaginal yeast infections?	YES	NO
Are you pregnant?	YES	NO
Are you currently planning a pregnancy	YES	NO

Please inform the doctor at any time if you do plan to or become pregnant during you treatment.

5. WHAT MEDICATIONS, DRUGS, OR OVER-THE-COUNTER PREPARATIONS ARE YOU NOW TAKING? (e.g. for constipation, sleep, headaches, birth control, anxiety) Please list all

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6. PRIOR HOSPITALIZATIONS AND SURGERY (PLEASE GIVE APPROXIMATE DATES)

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TO ALL PATIENTS – PLEASE READ AND ANSWER "YES" OR "NO"

It is strongly recommended, at the initial visit, that you have the doctor examine your entire skin surface. Even if you have just been to your family physician, it is recommended that you have your dermatologist examine your skin, thus extending but not replacing, a complete physical examination by your family physician. If you desire this examination, you will be given a disposable gown. Please completely disrobe to allow the doctor to view your entire skin surface for medically important benign or malignant lesions.

Do you wish to have this examination? …………………………………………… YES NO

Patient Acknowledgments of Brody Dermatology Office Policies

Insurance Information

Co-payments and Deductibles
Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $15 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or collection fee at the provider's current rate may be charged on all balances that are past due. Your signature below signifies your understanding and willingness to comply with this policy.

____ ______________
Patient Signature Date

Referral Information
If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits; Brody Dermatology will reschedule my appointment.

____ ______________
Patient Signature Date

Insurance Cards
New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by signing below that I am responsible for notifying the office of any changes to my insurance contact information.

____ ______________
Patient Signature Date

HIPAA Policy
Patients over the age of 18 are protected under Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Brody Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain test results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual (please print)	Relationship to Patient

Do we have your permission to

Leave a message on your answering machine at home? YES NO
Leave a message at your place of employment? YES NO

____ ______________
Patient Signature Date

Release of Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Should my insurance company send payment for these services to me rather than directly to Dr. Brody, I agree to forward that check or my equivalent personal check to the doctor immediately.

Patient or Responsible Party Signature ____ Date___/___/___

Payment Policy

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $100.00 deductible and paying for the 20% co-insurance.

HMO, PPO or other Managed Care Patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services.

I also understand that I am personally responsible for payment for these services in the event that:

- There has been a lapse in my coverage or that it has been terminated.
- My insurance company refuses to pay because of a requirement that has not been met by either myself or my referring physician.
- My insurance company refuses to pay because it is not the primary carrier.
- If for any reason your insurance company does not pay us.

The rules that insurance companies use to determine payment on procedures and diagnoses changes on a daily basis. Since we are not informed of these changes, we can not be responsible for informing you in advance for each procedure. Therefore, when your insurance company does not cover a procedure we will consider it cosmetic and you will be billed by our office.

Patient or Responsible Party Signature ____Date___/___/___