



Patient Information

Please present picture ID and Insurance card

Name: Last First M.I. (Preferred Name)

Address: Street City State Zip

Date of Birth: / / Age: Gender: M F Marital Status: S M D W

Ethnicity: SSN: Primary Contact Number: Home Cell Work

Home: Cell: Work: Ext:

Email: Pharmacy & Location:

Employer: Occupation:

In case of emergency, notify: Phone: Relationship

Who is your family doctor? Phone:

I hereby authorize Pinnacle Dermatology, SC to treat my child in my absence. Parent Signature

Insurance Subscriber (Check if same as above)

Name: Last First M.I. SS#

Address: Street City State Zip

Work Phone: Ext. Home Phone:

Cell Phone: Date of birth: Relationship to patient:

Insurance Information (Please present card at time of check-in.)

Primary Insurance name: Secondary Insurance name:

Policy Holder: Policy Holder:

Contract #: Contract #:

Group #: Group #:

Relationship to patient: Relationship to patient:

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this provider for any services furnished me by this physician. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine benefits for related medical services. I authorize Medicare to furnish the above-named doctor any information regarding my medical claims under Title XVII of the Social Security Act.

Commercial Insurance

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the doctor indicated on the claim. I understand I am financially responsible for any balance not covered by insurance. I give consent for Pinnacle Dermatology, SC to communicate with my referring physician.

Patient or Guardian Signature: Date: / /

What are your concerns today and when did the problem(s) begin? \_\_\_\_\_

Which Pharmacy do you currently use? \_\_\_\_\_ Phone Number \_\_\_\_\_

### Medical History

Select any of the following medical conditions that you currently have.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Leukemia <input type="checkbox"/> |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> End Stage Renal Disease | Lung Cancer <input type="checkbox"/>                       |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> GERD                    | Lymphoma   |
| <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Prostate Cancer                   |
| <input type="checkbox"/> Bone Marrow Transplant  | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Radiation Treatment               |
| <input type="checkbox"/> BPH                     | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Seizures                          |
| <input type="checkbox"/> Breast Cancer           | <input type="checkbox"/> HIV / AIDS              | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> Colon Cancer            | <input type="checkbox"/> Hypercholesterolemia    | <input type="checkbox"/> NONE                              |
| <input type="checkbox"/> COPD                    | <input type="checkbox"/> Hyperthyroidism         | <input type="checkbox"/> Other: _____                      |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypothyroidism          | _____  |
| <input type="checkbox"/> Depression              |  |  |

### Past Surgical History

Select any organs that you have had previous surgeries.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Appendix (Appendectomy)                       | <input type="checkbox"/> Joint Replacement: Knee (Right, Left, Bilateral) | <input type="checkbox"/> Prostate (Prostatectomy): TURP         |
| Bladder (Cystectomy)   | <input type="checkbox"/> Kidney: Kidney Biopsy                            | Rectum: APR   |
| Breast: Breast Biopsy  | <input type="checkbox"/> Kidney: Kidney Stone Removal                     | <input type="checkbox"/> Rectum: Low Anterior Resection         |
| <input type="checkbox"/> Breast: Lumpectomy (Right, Left, Bilateral)   | <input type="checkbox"/> Kidney: Kidney Transplant                        | <input type="checkbox"/> Skin: Basal Cell Carcinoma             |
| <input type="checkbox"/> Breast: Mastectomy (Right, Left, Bilateral)   | Kidney: Nephrectomy   | Skin: Melanoma  |
| <input type="checkbox"/> Colon (Colectomy): Colon Cancer Resection     | Liver: Hepatectomy  | Skin: Skin Biopsy   |
| Colon (Colectomy): Diverticulitis                                      | <input type="checkbox"/> Liver: Liver Transplant                          | <input type="checkbox"/> Skin: Squamous Cell Carcinoma          |
| <input type="checkbox"/> Colon (Colectomy): Inflammatory Bowel Disease | <input type="checkbox"/> Live: Shunt                                      | <input type="checkbox"/> Spleen (Splenectomy)                   |
| <input type="checkbox"/> Colon: Colostomy                              | <input type="checkbox"/> Ovaries (Oophorectomy): Endometriosis            | <input type="checkbox"/> Testicles (Orchiectomy)                |
| Gallbladder (Cholecystectomy)  | <input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cancer           | Uterus (Hysterectomy): Fibroids                                 |
| Heart: Coronary Artery Bypass Surgery                                  | <input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cyst             | <input type="checkbox"/> Uterus (Hysterectomy): Uterine Cancer  |
| Heart: Heart Transplant  | <input type="checkbox"/> Ovaries: Tubal Ligation                          | <input type="checkbox"/> Uterus (Hysterectomy): Cervical Cancer |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement           | Pancreas: Pancreatectomy  | NONE  |
| Heart: PTCA  | <input type="checkbox"/> Prostate (Prostatectomy): Prostate Biopsy        | Other   |
| Joint Replacement: Hip (Right, Left, Bilateral)                        | Prostate (Prostatectomy): Prostate Cancer                                 |   |

## Medical History Continued

### Have you had any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Hay Fever / Allergies     |
| <input type="checkbox"/> Actinic Keratoses      | <input type="checkbox"/> Melanoma                  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Poison Ivy                |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Precancerous Moles        |
| <input type="checkbox"/> Blistering Sunburns    | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Eczema                 | <input type="checkbox"/> NONE                      |
| <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Other: _____              |

Do you use Sunscreen?  Yes  No If Yes, what SPF? \_\_\_\_\_ Do you Tan indoor or outdoor?  Yes  No

Do you have a family history of Skin Cancer?  Yes  No If yes which relative(s)? \_\_\_\_\_

Do you have a family history of Melanoma?  Yes  No If yes which relative(s)? \_\_\_\_\_

List all current medications you take or apply regularly: \_\_\_\_\_

Do you need to take antibiotics before any surgeries or dental procedures?  Yes  No

If yes, what \_\_\_\_\_

List all allergies and reactions if known: \_\_\_\_\_

- I want my skin checked for skin cancer (Full Body Exam)
- I want my skin checked for skin cancer (Full Body Exam), and I will call at a later date to make an appointment.
- No, I do not want my skin checked for skin cancer. (Decline a Full Body Exam)

### Social History

#### Smoking Status (please choose one):

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

#### Start Smoking:

- mm/dd/yyyy - \_\_\_\_\_

#### Quit Smoking:

- mm/dd/yyyy - \_\_\_\_\_

Number of Packs Per Day: \_\_\_\_\_

Total Years Smoking: \_\_\_\_\_

#### Alcohol Intake (Please Choose one)

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

#### Driving Status:

- Drives in the Daytime
- Drives at Night

**Social History Continued**

<p><b>How often do you exercise?</b></p> <p><input type="checkbox"/> Unspecified</p> <p><input type="checkbox"/> Several times a day</p> <p><input type="checkbox"/> Once a day</p> <p><input type="checkbox"/> A few times a week</p> <p><input type="checkbox"/> A few times a month</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Other</p> <hr/>	<p><b>What is your caffeine use?</b></p> <p><input type="checkbox"/> Unspecified</p> <p><input type="checkbox"/> Several times a day</p> <p><input type="checkbox"/> Once a day</p> <p><input type="checkbox"/> A few times a week</p> <p><input type="checkbox"/> A few times a month</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Other</p> <hr/>
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**Cosmetic Concerns**

*What are your skin care or cosmetic concerns? Please circle all that apply*

**Facial Concerns**

Brown spots	White heads	Black heads	Sun damage
Spider veins	Yellow/stained teeth	Redness	Loss of elasticity
Loss of facial volume	Wrinkles/lines	Enlarged pores	Sensitivity
Oily skin	Excess hair	Non-matching makeup	Uneven skin texture
Dry skin	Thin lips	Scars	Other:

**Body Concerns**

Scars	Excessive sweating	Appearance of chest	Fragile/brittle nails
Sagging skin	Excess fat	Dry body skin	Cellulite
Stretch marks	Body acne	Sun damage	Spider veins
Thinning hair	Other:	Other:	Other:

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

### Medical History Review of Systems

Please circle **ALL** conditions that apply, please check **NO** if none of the conditions apply

System Review	Circle all that apply (Presently)	No	Comments/Other
Constitutional	Fevers, chills, night sweats		
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching, eczema		
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness, earache, nasal polyps, ear ringing		
Eyes	Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma		
Respiratory	Shortness of breath, asthma, difficulty breathing, emphysema, bronchitis, tuberculosis		
Cardiovascular	Heart attack, irregular heartbeat, heart murmur, chest pain, high blood pressure		
Gastrointestinal	Ulcer, hepatitis, weight changes, bowel changes, weight gain, weight loss, liver problems, intestinal disorders, reflux		
Genitourinary	Painful urination, difficulty urinating, blood in urine, renal disease/failure, frequent urination, kidney problems		
Musculoskeletal	Arthritis, weakness, back pain, joint pain, cramps, stiffness, osteoporosis		
Neurologic	Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines, myasthenia gravis		
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness		
Endocrinology	Intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue, diabetic		
Hematologic	Blood clots, anemia, bleeding problems, hepatitis, blood transfusions, platelet disorder		
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes		
Other Medical Problems	Such as: Cancers, infectious disease, HIV, autoimmune disease, etc.		

Have you had an annual flu shot? Yes: \_\_\_\_\_ Date: \_\_\_\_\_ No: \_\_\_\_\_

Are you pregnant or nursing? \_\_\_\_ Yes \_\_\_\_ No      If Yes how far along: \_\_\_\_\_

Are you planning on getting pregnant? \_\_\_\_ Yes \_\_\_\_ No    Is your menstrual cycle regular? \_\_\_\_ Yes \_\_\_\_ No

Have you ever taken Accutane? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

I consent to being tested for hepatitis / HIV (AIDS) if an office staff member is directly exposed to potentially contagious material (i.e., needle stick). **Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The Health Care Provider signature below indicates this entire form was reviewed to include:  
allergies · past medical history · family history · social history surgical history · medications · review of systems

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Doctor, nurse practitioner, physician assistant)

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

### Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. The following information outlines your responsibility related to payment and appointment reservation for professional services. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

**Insurance:** At each visit we must verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage.

**Co-payment:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payment and co-insurance are determined by your insurance. We accept cash, check, Visa, MasterCard, American Express, Discover and Care Credit.

**Deductible:** An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

**Credit Card on File:** For any prearranged payment plans, Pinnacle Dermatology, SC will keep credit cards on file (CCOF). We do not keep any credit card information on file in the office or on any of our computers. We use a secure, encrypted gateway that is completely compliant as required by law.

**Referrals:** If your insurance company requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain one. If the referral is not sent to us prior to your scheduled appointment you may be asked to reschedule the visit until we have a valid referral on file. It is also your responsibility to ensure that your PCP is listed correctly with your insurance company. If the PCP is not correct at the time of service, you will be responsible to pay for the cost of services rendered.

**Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is available for subsequent visits. All co-pays or monies due are expected to be paid at the time of each service.

**Determining Guarantor:** The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if they are over the age of 18. The guarantor for a minor child is the parent that presents the child for care at the time of the initial visit.

**Non-Payment:** If your account is 120 days past due, we will refer your account to an external collection agency. Once the account has been placed with the agency, we will add a 30% collection fee that will need to be paid in full along with the past due balance to schedule future appointments with Pinnacle Dermatology, SC. The collection vendor may report your delinquency to a credit bureau and may file litigation in efforts to collect the total balance due. Any litigation fees will be applied to the collection balance.

**Returned Checks:** Pinnacle Dermatology, SC will charge a \$35 fee for any returned checks.

**Missed Appointments:** If you are unable to keep your appointment please notify our office at least 24 hours in advance. Failure to provide 24-hour notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. The no-show fee is \$50 for a Monday-Friday regular medical visit and \$100 for Saturday appointments. The no-show fee is \$99 for a cosmetic consultation and \$250 for a cosmetic procedure. No-show charges are not billable to your insurance.

*I have read and understand the Financial Policy and agree to its terms.*

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

### Patient HIPAA Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Authorization in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Authorization.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Consent for Verbal Release of Information

Preferred Number	Type (please circle)	Leave Detailed Message (please circle)	Leave Detail Lab/Test Result (please circle)
Primary Phone #:	Home/Work/Cell	Yes/No	Yes/No
Secondary Phone #:	Home/Work/Cell	Yes/No	Yes/No

Please note the voice mail message must have an identifying message to confirm these are your numbers for example; "You have reached John Doe". If the message does not identify your name, we will be unable to leave a detailed message even if you opted us to do so.

I hereby give permission to Pinnacle Dermatology, SC to notify me by telephone, text, and/or email for the following:

- Appointment Reminders
- A message to call the office for test results (actual results will not be left)
- Benign results, a message will be left, stating no further treatment would be needed and to keep any advised follow up as recommended by the provider.

I authorize Pinnacle Dermatology, SC to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history, or any other such related information to myself and those listed below.

Name	Phone Number	Relationship

Assisted living/Long term care facility residents:

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Power of Attorney Name	Relationship to Patient
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Telephone Number	Date of POA Received
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\*Please note the POA is only valid if we have the paperwork scanned into the patient's medical record

Please list any facility personnel we can speak with on your behalf regarding your medical information:

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Name	Telephone Number	Relationship
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*I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Pinnacle Dermatology, SC locations and providers. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the Pinnacle Dermatology, SC. I also understand that I will not be able to revoke this consent in cases where the provider has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the provider's office.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_