PATIENT INFORMATION *(Please Print)* Today's Date _____/_____/_____

Name _____
Last First MI

Address _____
Street City State Zip

Home Phone ( )_____ Work Phone ( ) _____ Cell Phone ( ) _____

Marital Status S / M / W / D Date of Birth _____/_____/_____ SS# _____ Sex _____ Age _____

Race/ethnicity_____ Email address:_____

Referred by _____ Employer: _____ ☐ **HIPAA Consent Signed**

RESPONSIBLE PARTY or LEGAL GUARDIAN **(if different from patient)**

Name _____ Relationship to patient _____
Last First

Address:_____
Street City State ZIP Code

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

DOB:_____ SS# _____

INSURANCE INFORMATION **(Please Provide Copy of Insurance Card)**

Primary Insurance Name_____ PPO / HMO / POS Insured's ID# _____

Name of Insured _____ Insured's Employer _____

Relationship to patient _____ Insured DOB _____/_____/_____ Group# _____

Secondary Insurance Name_____ PPO / HMO / POS Insured's ID# _____

Name of Insured _____ Insured's Employer _____

Relationship to patient _____ Insured DOB _____/_____/_____ Group# _____

ADDITIONAL INFORMATION

May we leave personal medical/billing information on your answering machine/voicemail? ☐ YES ☐ NO

Do you give our office permission to discuss your medical/billing information with family members? ☐ YES ☐ NO

If yes, please provide their names, their relationship to the patient, their date of birth and the last four (4) digits of their SS# below:

Name/Relationship: _____ DOB: _____/_____/_____ Last 4-digits of SS#: _____

Name/Relationship: _____ DOB: _____/_____/_____ Last 4-digits of SS#: _____

Other family members that are patients _____

In case of Emergency, who should be notified? _____

Relationship to patient _____ Phone _____

By signing below I indicate that the information above is accurate and correct to the best of my knowledge and ability.

Patient / Guardian Signature: _____

CONTINUED ON BACK

GENERAL CONSENT AND FINANCIAL AGREEMENT

1. CONSENT TO TREATMENT: I, the undersigned, hereby consent to medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. I understand that no guarantee has been made as to the results that may be obtained.

2. RELEASE OF INFORMATION: I authorize the release of any or all medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

3. FINANCIAL POLICY: In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-insurance, and deductibles will be collected.

4. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment of medical benefits to the treating physician/practice. I understand that I am responsible for any health insurance deductible, co-payments, co-insurance and non-covered services.

5. ACKNOWLEDGEMENT: My signature below acknowledges that I have read and understand each of the preceding sections 1 through 4.

_____ Date: _____

(Patient or Person Authorized to Consent)

_____ _____

(Print Name if other than Patient) (Relationship to Patient)

MEDICARE PATIENTS READ AND SIGN BELOW

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____/_____/_____

Signature as it appears on Medicare Card **Date**

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____

Signature as it appears on Medigap Card **Date**

Patient Name:_____

Skin Disease History: (please circle all that apply)

Acne	Flaking or Itchy Scalp	
Actinic keratoses	Hay Fever/Allergies	
Asthma	Melanoma	None
Basal cell skin cancer	Poison Ivy	
Blistering sunburns	Precancerous moles	
Dry skin	Psoriasis	
Eczema	Squamous cell skin cancer	

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)? _____

Medications: (Please list all current medications, dose, and frequency)

_____
_____
_____

Are you allergic to any medications? If yes, please list.

_____
_____
_____

Social History

Smoking status (please choose one)
Current every day smoker
*# of packs per day*_____
*Appox. date you began smoking:*_____
Current someday smoker
Former smoker *Quit date:*_____
Cigar smoker
Never smoker

Alcohol Intake (please choose one)
None
1 or less per day
1-2 per day
3 or more per day

CONTINUED ON BACK PAGE

Medical and Surgical History

Past Medical History: (please circle all that apply)

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

Other _____

Past Surgical History: (please circle all that apply)

Appendix (Appendectomy)	Ovaries Removed: Endometriosis
Bladder (Cystectomy)	Ovaries Removed: Cyst
Breast: Mastectomy (Right, Left, Both)	Ovaries Removed: Ovarian Cancer
Breast: Lumpectomy (Right, Left, Both)	Ovaries: Tubal Ligation
Breast Biopsy	Pancreas: Pancreatectomy
Colon: Colectomy: Colon Cancer Resection	Prostate: Prostate Cancer
Colon: Colectomy: Diverticulitis	Prostate Biopsy
Colon: Colectomy: Inflammatory bowel disease	Prostate: TURP
Gallbladder (Cholecystectomy)	Rectum: APR
Heart: Coronary Artery Bypass	Rectum: Low Anterior Resection
Heart: Heart transplant	Skin Biopsy
Heart: PTCA	Skin: Basal Cell Cancer
Heart: Mechanical Valve Replacement	Skin: Squamous Cell Carcinoma
Joint Replacement, Knee (Right, Left, Both)	Skin: Melanoma
Joint Replacement, Hip (Right, Left, Both)	Spleen (Splenectomy)
Kidney Biopsy	Testicles (Orchiectomy)
Kidney Stone Removal	Hysterectomy: Fibroids
Kidney Transplant	Hysterectomy: Uterine Cancer
Kidney: Nephrectomy	Hysterectomy: Cervical Cancer
Liver: Hepatectomy	
Liver: Liver Transplant	None
Liver: Shunt	

Other _____

NEBRASKA DERMATOLOGY, L.L.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I,_____, have reviewed a copy of Nebraska Dermatology's
(print patient's name)

Notice of Privacy Practices.

_____
Signature of Patient or Legal Guardian

_____
Date