EPIPHANY® DERMATOLOGY

PATIENT INFORMATION FORM

Please complete both sides of this form in ink and sign where indicated.

PATIENT INFORMATION

Date ____/____/_____

Patient Name (last, first, middle initial) _____ Preferred Name _____

Date of Birth: ____ / ____ / _____ Social Sec. # _____ Gender: ◯ Male ◯ Female

Mailing Address: Street _____

City _____ State _____ ZIP _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

Email Address: _____

(We will never give out your email address without your written permission.)

Primary Care Physician: _____ Referring Physician: _____

PARENT, SPOUSE OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name (last, first, middle initial) _____

Date of Birth: ____ / ____ / ____ Social Sec. # _____ Gender: ◯ Male ◯ Female

Mailing Address: Street _____

City _____ State _____ ZIP _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

Email Address: _____

INSURANCE INFORMATION

INSURANCE COVERAGE – PRIMARY

Insurance Company Name _____

Policy/ID Number _____

Name of Policy Holder (Insured) _____ Date of Birth: ____ / ____ / _____

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other _____

INSURANCE COVERAGE – SECONDARY (IF APPLICABLE)

Insurance Company Name _____

Policy/ID Number _____

Name of Policy Holder (Insured) _____ Date of Birth: ____ / ____ / _____

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other _____

RELEASE OF INFORMATION

Other than yourself, with whom may we discuss your medical information?

(Please give the person's' name and relationship to you.)

_____

_____

EMERGENCY CONTACT INFORMATION

Name of Friend or Relative: _____

Relationship to Patient: _____

Address: _____

Home Phone: _____

Mobile Phone: _____

LEGAL INFORMATION

Assignment of Benefits: *The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Epiphany Dermatology and its related companies. I understand that I am financially responsible for any balance. I also authorize Epiphany Dermatology, its related companies, or insurance company to release medical information required to process claims.*

Notice of Privacy Practices: *I have read or been offered a copy of Epiphany Dermatology's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.*

Authorizations: *I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that medical treatment may include a review of medical history, discussion of reason for visit and medical photographs of the area being discussed. I authorize Epiphany Dermatology and its related companies to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Epiphany Dermatology's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Epiphany Dermatology.*

Financial Responsibility: *Health insurance benefits are verified as a courtesy and are an estimate only. Final patient responsibility is based on the insurance explanation of benefits once the claim is processed.*

Consent for Communication: *I understand Epiphany Dermatology will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.*

Payment Policy: *Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Epiphany Dermatology and its related companies.*

Late or Missed Appointment Policy: *We require a 24-hour cancellation notice if you are not able to keep your appointment. No-show appointments are subject to a no-show fee (including surgery and cosmetics) as missed appointments prevent other patients from seeing our providers in a timely fashion. See office "Late or Missed Appointment Policy" for pricing.*

Legal: *This form applies to Epiphany Dermatology and its related companies.*

Patient Rights: *I have read or been offered a copy of Epiphany Dermatology Patient Rights.*

Patient Rights Document Received: ◯ *Received* ◯ *Declined.*

SIGNATURE

Patient / Guardian Signature: _____ *Date:* _____

EPIPHANY DERMATOLOGY

MEDICAL HISTORY AND INTAKE FORM

PATIENT INFORMATION

Patient Name: _____ *Date of Birth:* _____

Reason for Visit, loction of problem, duration of problem: _____

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

- ○ *Allergies (Seasonal)*
- ○ *Asthma*
- ○ *Bleeding Disorder (or bleeding issue)*
- ○ *Cancer:*_____
- ○ *Coronary Artery Bypass*
- ○ *Depression*
- ○ *Diabetes*
- ○ *Fever Blister*
- ○ *Heart Valve Replacement*
- ○ *High Blood Pressure*
- ○ *High Cholesterol*
- ○ *HIV/AIDS*
- ○ *Joint Replacement*
- ○ *Kidney Transplant*
- ○ *Liver Disease*
- ○ *Lumpectomy*
- ○ *Lupus / Rheumatoid Arthritisocer*
- ○ *Mastectomy*
- ○ *Organ Transplant*
- ○ *Thyroid Disease*
- ○ *NONE*

DISEASED YOU HAVE A HISTORY OF SKIN CANCER OR SKIN DISORDERS?

(Examples: acne, actinic keratosis, basal cell, melanoma, psoriasis, squamous cell) Yes_____ No_____

If yes, please indicate condition or disorder: _____

FAMILY HISTORY OF SKIN CANCER INCLUDING MELANOMA? *Yes_____ No_____*

If yes, whom: _____

MEDICATIONS: *(Enter all current medications including non-prescription and birth control; if none mark N/A)*

_____

ALLERGIES: *(Please enter all allergies including allergy to medications; if none mark N/A)*

_____

SOCIAL HISTORY:

*Do you smoke? Yes___ No___ If yes, how much?*_____

*Do you drink alcohol? Yes___ No___ If yes, how much?*_____

REVIEW OF SYSTEMS: (CHECK ALL THAT APPLY)

- ○ *Problems with bleeding*
- ○ *Problems with healing*
- ○ *Problems with scarring/keloids*
- ○ *Fever or Chills*
- ○ *Night sweats*
- ○ *Unintentional weight loss*
- ○ *Joint pain*

ALERTS: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

- ○ *Allergy to Adhesive*
- ○ *Allergy to Lidocaine*
- ○ *Allergy to Topical Antibiotics*
- ○ *Artificial Heart Valve*
- ○ *Artificial Joint Replacement*
- ○ *Blood Thinners*
- ○ *Defibrillator*
- ○ *MRSA*
- ○ *Pacemaker*
- ○ *Require antibiotics prior to a surgical procedure*
- ○ *Rapid heart beat with Epinephrine*
- ○ *Are you pregnant or currently trying to get pregnant?*
- ○ *Breastfeeding*
- ○ *NONE*

NONEPREFERRED PHARMACY

Preferred Pharmacy Name: _____ *Telephone (if known):* _____

*Address (or cross streets):*_____ *City:* _____