DermOne™
Dermatology Centers

History and Intake Form

Patient Name:_____ Today's Date:_____
DOB: ____/____/_____ Age:_____
Primary Care Physician_____ Referring Physician_____
Referring Physicians & possibly other physicians will be updated of your care unless you circle: Do Not Update

Past Medical History:

Anxiety	Y/N	Depression	Y/N	Hyperthyroidism	Y/N
Arthritis	Y/N	Diabetes	Y/N	Hypothyroidism	Y/N
Asthma	Y/N	End Stage Renal Disease	Y/N	Leukemia	Y/N
Atrial Fibrillation	Y/N	GERD/Acid Reflux	Y/N	Lung Cancer	Y/N
Bone Marrow Transplantation	Y/N	Hearing Loss	Y/N	Lymphoma	Y/N
BPH/Benign Prostate Enlargement	Y/N	Hepatitis	Y/N	Prostate Cancer	Y/N
Breast Cancer	Y/N	Hypertension/High Blood Pressure	Y/N	Radiation Treatment	Y/N
Colon Cancer	Y/N	HIV/AIDS	Y/N	Seizures	Y/N
COPD	Y/N	High Cholesterol	Y/N	Stroke	Y/N
Coronary Artery Disease	Y/N				

Other_____

Past Surgical History:

Appendix (Appendectomy)	Y/N	Joint Replacement, Knee *(Right/Left/Bilateral)*	Y/N	Prostatectomy: Prostate Cancer	Y/N
Bladder (Cystectomy)	Y/N	Kidney Biopsy	Y/N	Prostatectomy: TURP	Y/N
Breast Biopsy *(Right/Left/Bilateral)*	Y/N	Kidney Stone Removal	Y/N	Rectum: APR	Y/N
Lumpectomy *(Right/Left/Bilateral)*	Y/N	Kidney Transplant	Y/N	Rectum: Low Anterior Resection	Y/N
Mastectomy *(Right/Left/Bilateral)*	Y/N	Kidney Removed/Nephrectomy *(Right/Left)*	Y/N	Skin: Basal Cell Cancer Surgery	Y/N
Colectomy: Colon Cancer Resection	Y/N	Liver: Hepatectomy	Y/N	Skin: Melanoma	Y/N
Colectomy: Diverticulitis	Y/N	Liver Transplant	Y/N	Skin Biopsy	Y/N
Colectomy: Irritable Bowel Disease	Y/N	Liver: Shunt	Y/N	Squamous Cell Cancer Surgery	Y/N
Colon: Colostomy	Y/N	Ovaries Removed: Endometriosis	Y/N	Spleen Removed	Y/N
Gallbladder (Cholecystectomy)	Y/N	Ovaries Removed: Ovarian Cancer	Y/N	Testicles Removed	Y/N
Biological Valve Replacement	Y/N	Ovaries Removed: Ovarian Cyst	Y/N	Hysterectomy *(Fibroids, Uterine Cancer, Cervical Cancer)*	Y/N
Coronary Artery Bypass	Y/N	Ovaries: Tubal Ligation	Y/N	Other_____	
Heart Transplant	Y/N	Pancreas Removed	Y/N		
Mechanical Valve Replacement	Y/N	Prostate Biopsy	Y/N		
PTCA/Angioplasty	Y/N				
Joint Replacement, Hip *(Right/Left/Bilateral)*	Y/N				

Skin Disease History:

Acne	Y/N	Dry Skin	Y/N	Poison Ivy	Y/N
Actinic Keratoses	Y/N	Eczema	Y/N	Precancerous Moles	Y/N
Asthma	Y/N	Flaking or Itchy Scalp	Y/N	Psoriasis	Y/N
Basal Cell Skin Cancer	Y/N	Hay Fever or Allergies	Y/N	Squamous Cell Skin Cancer	Y/N
Blistering Sunburns	Y/N	Melanoma	Y/N	Other_____	

DermOne™
Dermatology Centers

History and Intake Form (Continued)

Do you wear sunscreen? Y/N If yes, what SPF?_____

Do you tan in a tanning salon? Y/N

Have any family members had Melanoma? Y/N

If yes, which relative(s) (i.e. Mother, Nephew)?_____

Do you faint easily with procedures? Y/N

Medications: (Please enter all current medications)_____

_____

_____

Allergies: (Please enter all allergies and reactions experienced)_____

_____

_____

Social History:

Currently Smokes	Y/N	Sexually Active with One Partner	Y/N	Alcohol Use	Y/N
Has Smoked in the Past	Y/N	Drug Use	Y/N	Drinks per Day	___

Review of Systems: Are you currently experiencing any of the following?

***If yes to any of these symptoms, please follow up with your primary care provider as we only treat dermatological conditions.*

Pacemaker	Y/N	Scarring (Keloid/Hypertrophic)	Y/N	Muscle Weakness	Y/N
Defibrillator	Y/N	Immunosuppression	Y/N	Neck Stiffness	Y/N
Artificial Joints *(within past 2 years)*	Y/N	Changing Mole	Y/N	Night Sweats	Y/N
Artificial Heart Valve	Y/N	Rash	Y/N	Seizures	Y/N
Meds Required Prior to Procedure	Y/N	Abdominal Pain	Y/N	Shortness of Breath	Y/N
Adhesive Allergy	Y/N	Anxiety	Y/N	Sore Throat	Y/N
Allergy to Topical Antibiotics	Y/N	Bloody Stool	Y/N	Thyroid Problems	Y/N
Blood Thinners	Y/N	Bloody Urine	Y/N	Unintentional Weight Loss	Y/N
Pregnant or Planning Pregnancy	Y/N	Blurry Vision	Y/N	Wheezing	Y/N
Allergy to Lidocaine	Y/N	Chest Pain	Y/N	Aching, Burning or Tired Legs	Y/N
Rapid Heartbeat to Epinephrine	Y/N	Cough	Y/N	Leg Discoloration	Y/N
Yeast Infections with Antibiotics	Y/N	Depression	Y/N	Leg Swelling or Inflammation	Y/N
GI Upset with Antibiotics	Y/N	Fever or Chills	Y/N	Night Cramps	Y/N
Breastfeeding	Y/N	Headaches	Y/N	Restless Leg Syndrome	Y/N
Bleeding Problems	Y/N	Hay Fever	Y/N	Varicose Veins	Y/N
Problems Healing	Y/N	Joint Aches	Y/N	Other_____	

Are you interested in Cosmetic or Esthetic Services (Lasers, Fillers, Injectables, Peels, Product, etc.)? Y/N

Which Specific Services?_____

_____	___/___/_____	_____	___/___/_____
Patient Signature (or Guardian)	Date	Physician/Nurse	Date

Pharmacy of choice: _____

DermOne™
Dermatology Centers

Patient Information

Please answer all questions

Name: Last_____ **First**_____ **MI**_____
Birthdate_____ **Age**_____ **SS#**_____ **Sex** ☐ M ☐ F
Address_____ **Preferred Language**_____
City_____ **State**_____ **Race** ☐ White/Caucasian ☐ Black/African American
Zip Code_____ **4 digit**_____ ☐ Asian ☐ Hawaiian/Pacific Islander
Home Phone_____ ☐ Other Race ☐ American Indian/Alaskan
Mobile Phone_____ **Ethnic Origin** ☐ Hispanic ☐ Non-Hispanic
Work Phone_____ **Ext**_____ **Marital Status** S [ ] M [ ] D [ ] W [ ]
Email_____
How did you hear about us?_____
Were you referred? If yes, by: ☐ Primary Care Physician ☐ Other Physician ☐ Friend/Family ☐ Other
Referring Physician Name_____
Other Referral Source Name/Description _____

Emergency Contact

Name_____ **Phone**_____ **Relation**_____

Insurance Information

1) Insurance Co_____ **2) Insurance Co**_____
Insured's Name_____ **Insured's Name**_____
Relationship to Patient_____ **Relationship to Patient**_____
Insured's SS#_____ **Insured's SS#**_____
Insured's Date of Birth_____ **Insured's Date of Birth**_____
Employer_____ **Employer**_____

Responsible Party (This person must be present and sign this form)

Name_____ **Relation**_____
Birthdate_____ **SS#**_____
Address_____ **City/State**_____ **Zip**_____
Home Phone_____ **Mobile Phone**_____ **Work Phone**_____
Employer_____ **Address**_____

(1) Payment is required for all services at the time they are rendered; this may include but not be limited to a co-payment, co-insurance, or your bill in full if your insurance is one we do not file.

(2) I authorize the release of medical and personal information which may include but is not limited to: processing of medical claims and referring to other physicians.

(3)I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required).

(4) My right to payment for all procedures, tests, and nursing/ physician services including major medical benefits is hereby assigned to DermOne of North Carolina, P.A. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to DermOne of North Carolina, P.A.

(5) I agree to indemnify, defend and hold DermOne of North Carolina, P.A. harmless from any loss, damages, costs, or expenses in connection with false insurance information provided by patient.

Patient Signature_____ **Date**_____

Responsible Party Signature_____ **Relation**_____ **Date**_____

DermOne™
Dermatology Centers

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____, have been offered a copy of Atlantic Dermatology / DermOne of North Carolina, P.A.'s Notice of Privacy.

_____ ____/____/_____
Patient Signature (or Guardian) Date

If you would like a copy of our HIPAA guidelines, they are located in our lobby

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. We will continue to make reminder calls for patient's appointments.

I wish to be contacted in the following manner (check all that apply):

Home Phone

_____O.K. to leave a message with detailed information.

Mobile Phone

_____O.K. to leave a message with detailed information.

*Cell number that you can be reached at_____

Work Phone

_____O.K. to leave a message with detailed information.

Spouse/Other & Relation

_____O.K. to leave a message with detailed information,
and disclosing Confidential Medical Information.

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient / Guardian Signature_____ Date____/____/_____

Printed Name of Patient_____

Printed Name of Guardian and
Relationship to Patient (if applicable)_____

DermOne™
Dermatology Centers

DEDUCTIBLE AND HSA / HRA PLANS OFFICE POLICY WRITTEN ACKNOWLEDGMENT FORM

We participate with several major insurance carriers and file your claims as a courtesy. Our office policies concerning the Deductible and HSA/HRA plans are as follows: Patients are responsible for the coinsurance, deductibles, and copays in full. Payment is due at the time of service and is based on the patient's insurance company's contracted rates.

I, _____, have read and understand Atlantic Dermatology / DermOne of North Carolina, P.A.'s policy concerning Deductible and HSA/HRA plans.

Patient / Guardian Signature_____ Date____/____/_____

Printed Name of Patient_____

Printed Name of Guardian and
Relationship to Patient (if applicable)_____

DermOne™
Dermatology Centers

OFFICE POLICIES
WRITTEN ACKNOWLEDGMENT FORM

APPOINTMENTS: Patients are seen by appointment. For urgent and acute situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem, only so that patients with scheduled appointments are not kept waiting. Except in emergencies, patients with scheduled appointments will be seen before "work-in" patients.

We work very hard to keep our appointment schedule. However, because we see emergencies in the office there will inevitably be delays. We apologize in advance.

We will call to confirm most appointments two days in advance. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment. **We charge $25.00 for missed appointments.**

Cancellations for surgical appointments including MOHS surgery must be made 48 hours prior to your appointment. **A fee of $200.00 may apply if a 48 hour notice** is **not given.**

SOCIAL SECURITY NUMBERS: We handle patients' social security numbers and personal information in a confidential manner, but we may release personal and medical information to another doctor's office in the event of a referral. We use social security numbers for insurance and billing purposes. This is required information that we ask from each of our patients.

INSURANCE: Insurance is a contract between you and your insurance company. We are actually not involved in that contract. Therefore, we can not become involved in disputes between you and your insurance company regarding deductibles, co-payments, labs, or other charges. Currently, we file claims for Aetna, BCBS plans that can be filed through NC, Cigna, Coventry National, First Health, Inclusive Health, Medicare, Medcost, PMCS, United Health Care, and Tricare. For all other insurances, we will provide you with the required information so you can file your claim with your insurance company. If we are nonparticipating with your insurance plan, than you will be responsible for payment at the time the services are provided. If you have an insurance that has a co-payment, our office policy is to collect this before services are rendered. Also, if there is any change in your insurance carrier, it is your responsibility to inform us prior to your appointment.

You must have a current insurance card for us to file your insurance. If you do not have your card at the time of your appointment, you will be expected to pay in full if you wish to be seen, or your appointment can be rescheduled.

MINORS: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area.

PAYMENT: Payment is due from each patient at the time of service. We accept several different kinds of payment options. We gladly accept cash, check, Visa, Master Card, Discover, and Care Credit. With our Care Credit option, we offer 6 months interest free (with no minimum charge), and 24 months at 14.90% interest with a required minimum charge of $1000.00. If you are interested in applying for Care Credit, we can do the application process here in our office. It only takes a moment of your time, and we can get your application results within a few minutes. We do not bill parents or guardians not present in the office at the time of their appointment. If you are 18 years of age or older, we will not bill a parent or guardian - you will be responsible for the amount due at the time of service. Patients with co-pays, deductibles, percentages, etc. are expected to pay at the time of their appointment. Simply put, payment of any portion of your bill that you are responsible for "out of pocket" is expected at the time of your appointment. There will be a $35.00 service fee on all returned checks.

PHONE CALLS: You may need to contact the office with a question. Most calls will not be returned immediately. Please provide a return phone number where you can be reached for several hours, and/or provide additional phone numbers. In an emergency dial 911 first.

AFTER HOURS PROBLEMS: We are on call 24 hours a day, available only for urgent issues that can not wait for the office to open the next business day. To contact us, please call the office number.

ACKNOWLEDGMENT: I have read, understand, and agree to follow the above office policies.

Patient / Guardian Signature_____ Date____/____/_____

Printed Name of Patient_____

Printed Name of Guardian and
Relationship to Patient (if applicable)_____