Dermatology Clinic, P.C.

Larry W. Cole, M.D. ♦ Patrick J. Galaska, PA-C, MPAS

Last Name:________________________ First Name:________________________ MI:________

Address:____

City:____________________ State:______________ ZIP:____________

Mailing Address (if different):____

		May we leave you a message here?
Home Phone:	(_____) ____________	Y / N
Work Phone:	(_____) ____________	Y / N
Cell Phone:	(_____) ____________	Y / N

Email address:____________________________________

SSN#: _________-_____-_________ Date of Birth: _____/_____/______

Gender: M / F Marital Status: Married / Single / Other

A new HHS requirement for our electronic medical record;

Ethnicity: *Hispanic or Latino / Not Hispanic or Latino / I decline to answer*

Race: *American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /* Other

Preferred Language:____________ (english)

Preferred method of communication for patient reminders: Email / Telephone / Mail

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Primary Care Physician:__________________________________ Phone: (_____)__________

Referred by:____________________________________ Phone: (_____)__________

If patient is a minor: Parent's Name:________________________ Phone: (_____)__________

In Case of Emergency Contact:

Name:	Relationship:	Phone:	May we contact this person regarding your care?
________________________	____________	____________	Y / N

Insurance Company:______________________________ Group Number: ____________ ☐ See card

Policy Number:__________________________________ ☐ See card

Policy holder's Name:________________________ Relationship to Patient: self / spouse / parent / other

Policy holder's SSN#: _______-_____-_______ Date of Birth:________/_____/________

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Name ______________________ Date of Birth ____________ Date ____________

What are you being seen for? ______________________________

➢ Are you currently taking any medication? *Please include regularly used over the counter medications*

Medication Name	Dosage and Frequency (i.e. 10 mg twice a day, etc)

➢ Do you have any medication allergies?

Medication Name	Reaction

(Please continue on back if needed)

Pharmacy: ______________________ **Phone:** ( ) -

Address: ______________________________

Hay fever or other allergies? ______________________________

Smoking Status: Everyday / Occasional / Former / Never

Your past skin history

Do you have history of malignant melanoma, basal cell carcinoma, squamous cell carcinoma or pre-cancerous actinic keratosis? (circle all the apply)	Y	N
Do you use tanning beds?	Y	N
Have you ever been severely sunburned?	Y	N
Any radiation or ultraviolet treatments?	Y	N

Family History

Has anyone in your family had a malignant melanoma or any other skin cancer?	Y	N

Who? ____________ What type? (i.e. basal, squamous) ____________

Your past medical history

Do you have any heart disease, heart problems, pacemakers?	Y	N

Explain: ______________________

Do you have arthritis or artificial joints?	Y	N
Do you require antibiotics before dental or surgical procedures?	Y	N
Are you diabetic?	Y	N
Do you use insulin?	Y	N
Are you HIV positive?	Y	N
Any history of hepatitis?	Y	N
Any other major health problems not listed?	Y	N

If Yes: ______________________________

Is there a possibility that you are pregnant or are you presently trying to become pregnant? Y N (Female Patients only)

Please explain any other circumstance that the doctor may need to be aware of:
(Please continue on back if needed)

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Notice of Privacy Practices – Patient Acknowledgement

The Staff at the Dermatology Clinic, P.C. are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Signature below indicates you have been aware of the privacy policies of Dermatology Clinic, P.C. and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Financial & Information Release

Payment is expected at the time of service; insurance co-payments are mandated by your insurance company and **MUST** be made today. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I understand and agree that if the insurance company denies benefits for any reason, **I am responsible for the full amount of services provided**. I understand that the definition of "non-covered" or cosmetic procedures is made solely by my insurance company.

I request that payment of authorized insurance / Medicare benefits be made payable to Dermatology Clinic, P.C. (FEIN 26-4219515) on my behalf for services furnished to me. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection including attorney fees, collection fees and court costs and understand that I am no longer a patient at this office. I understand and agree to pay a returned check charge of $40.00 per returned check for any reason.

I authorize any holder of medical information about me to release any and all information to the health care financing administration, its agents, or my insurance carrier as needed to determine these benefits or the benefits for myself or my dependents. If I have health insurance coverage under an HMO or it is requested by any of my physicians, I authorize Dermatology Clinic, P.C. to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

***** ☐ I would like to receive a copy of my clinical summary after each visit*****

Signature of PATIENT (parent) **or INSURED:**

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Date:__________________________