PATIENT INFORMATION

Date:____________________

First Name:__________________________MI:______Last Name:_________________________

Date of Birth:_____________________________Sex: [ ] Male [ ] Female

Address:________________________________City,State,Zip:____________________________

Home Phone:________________________Cell Phone:__________________________________

Work Phone:_________________________Email Address:_______________________________

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Other

Primary Care Physician Name, City,State:____

Emergency Contact

Name:____Relationship:_____________________

Phone Number:__________________________Alt Phone Number:________________________

Responsible Party (if not patient)

Name:____Relationship:_____________________

Address:___________________________________City,State,Zip:_________________________

Patient Name:____**DOB:**________________

Past Medical History: (please circle all that apply)

NONE

Arthritis	Diabetes	High cholesterol
Asthma	End stage renal disease	Hyperthyroidism
Atrial fibrillation	Epilepsy (seizures)	Hypothyroidism
Cancer	GERD (reflux disease)	Leukemia
(type):________________	H/O Hypertension (BP)	Malignant lymphoma
Cerebrovascular acdnt (stroke)	Hearing loss	Malignant tumor of colon
COPD	Hepatitis:_________	Radiation treatment
Depression	HIV	Transplant of bone marrow

Other: ____

Past Surgical History: (please circle all that apply)

NONE

Bilateral replacement knee joints	Splenectomy (spleen removed)
Entire kidney transplant	Total replacement left hip joint
History of colectomy	Total replacement left knee joint
History replacement bilateral hip joints	Total replacement right hip joint
Hysterectomy	Total replacement right knee joint
Mechanical heart valve replacement	Transplant of heart
Oophorectomy (ovaries removed)	Transplant of liver

Other:____

Skin Disease History: (please circle all that apply)

NONE

Acne	Eczema	Squamous cell carcinoma
Actinic keratosis	Melanoma	Sunburn 2nd degree (blistering)
Basal cell carcinoma	Psoriasis	
Dysplastic mole (precancerous)	Rosacea	

Other:____

Do you wear sunscreen? YES NO
If yes, what SPF?__________
Do you tan in a tanning salon? YES NO

Patient Name:____**DOB:**________________

Family History:

Do you have a family history of melanoma? **YES** **NO**
If yes, which relative(s)?____

Do you have a family history of squamous cell carcinoma? **YES** **NO**
If yes, which relative(s)?____

Do you have a family history of basal cell carcinoma? **YES** **NO**
If yes, which relative(s)?____

Family history of other skin disease (parent(s), full sibling(s), children:____

Medications: (please enter all current medications or supply a list to be copied)

____
____
____

Allergies: (please enter all allergies)

____
____

Social History: (please circle all that apply)

Smoking habits:

Current every day smoker	Former smoker	Heavy tobacco smoker
Current some day smoker (tobacco)	Never smoker	Light tobacco smoker
Current some day smoker (cigarette)	Cigar smoker	

Alcohol Use:

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?___________________________

Do you consume alcohol (ethanol or grain alcohol)? (please circle)

None Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

Hermitage Dermatology Financial Policy
Thank you for choosing our practice for your dermatology needs. Our providers and staff are committed to providing you with the best possible care. Please understand that payment is considered part of your treatment. The following is our Financial Policy which we require you to read and sign prior to any treatment.

Payment
We accept the following forms of payment: **Cash, Check, Visa, MasterCard, American Express and Discover.** Payment for services is due at the time services are rendered unless prior arrangements have been made with our office. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our Office Manager, so that we can assist you in management of your account with a payment plan. Please note the parent that accompanies the minor child/children to the appointment is responsible for any payment due.

Insurance
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our relationship is with you. We are credentialed with most insurance carriers. **Please present your insurance card at the front desk so that we can file a claim on your behalf.** All charges are your responsibility whether your insurance company pays or not. Please be aware that not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what a covered benefit is and what is not. Patients are encouraged to check with their insurance carrier regarding benefits and coverage prior to their appointment. Fees for these services along with unmet deductibles and co-payments are due at the time of treatment. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary.

Check Processing
I give permission to Hermitage Dermatology (Lynn A. Colaiacovo, M.D., P.C.) to convert any paper check to an electronic transaction.

Authorization & Acceptance of Financial Policy
I authorize release of information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Lynn A. Colaiacovo, M.D. PC. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my
behalf. A photocopy of these assignments shall be valid as the original.

Printed Patient Name:____**DOB:**____________________

Signature of Patient or Personal Representative:____

Relationship to Patient:____**Date:**_______________________

Acknowledgment of Notice of Privacy Practices and Disclosure of Protected Health Information

By signing the acknowledgement to the Notice of Privacy Practices and Disclosures of Protected Health Information, I further authorize Hermitage Dermatology (Lynn A. Colaiacovo, M.D., P.C.) to allow the following:

To leave a message on my answering machine or on my voicemail. **[ ] YES [ ] NO**

To send me information via text message. **[ ] YES [ ] NO**

To send me information via e-mail. **[ ] YES [ ] NO**

I consent to release information to:

_____ Spouse **Name:____**

_____ Father **Name:____**

_____ Mother **Name:____**

_____ Children **Name(s):____**

_____ Grandparent(s) **Name(s):____**

_____ Sibling(s) **Name(s):____**

_____ Other **Name(s) & relationship:____**

*****If there is a change in your consent to release information to any of the parties checked above, it is YOUR responsibility to update the present acknowledgment form on file.**

By signing this page you agree to allow Hermitage Dermatology (Lynn A. Colaiacovo, M.D., P.C.) to disclose your health information with those you have indicated above, and the means in which we may leave information for you. Also, you acknowledge that you have received a copy of the “Notice of Privacy Practices”.

Signature of Patient or Personal Representative:____

Relationship to Patient:____

Printed Name:____Date:______________________

Patient Name:____DOB:______________________

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. **Our full-length Notice will be distributed to you upon arrival for your appointment.**

Date of Last Revision: September 23, 2013

This information is made available at your initial visit to our practice and at any other time requested by a patient.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is confidential.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices.)

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- Courtesy balance reminders
- Quality Assurance
- For research
- To avert a serious threat to health or safety
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or disputes

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our privacy officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices.