# LONE PINE
## DERMATOLOGY AND MOHS SURGERY


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**ALL INFORMATION WILL BE KEPT CONFIDENTIAL, PLEASE COMPLETE ALL FIELDS**

## PATIENT INFORMATION

NAME: _____ (FIRST / MIDDLE / LAST)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ (STREET/APT # / CITY / STATE / ZIP CODE)

PHONE: _____ ☐ HOME ☐ WORK ☐ CELL LEAVE A MESSAGE ☐ YES ☐ NO

EMAIL: _____

PHYSICIAN WHO SENT YOU? _____ PRIMARY CARE PHYSICIAN ? _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCED GENDER AT BIRTH: ☐ MALE ☐ FEMALE

RACE: ☐ ASIAN ☐ BLACK/AFRICAN ☐ CAUCASIAN ☐ HISPANIC/LATINO ☐ NATIVE AMERICAN ☐ PACIFIC ISLANDER

EMERGENCY CONTACT: _____ (NAME / RELATIONSHIP / PHONE NUMBER)

## INSURANCE INFORMATION

**PRIMARY** INSURANCE COMPANY: _____ SUBSCRIBER'S ID/ OR SS#: _____

POLICY HOLDER NAME: _____ (FIRST / MIDDLE / LAST) DATE OF BIRTH: _____

PHONE: _____ PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY : _____

ADDRESS: _____ (STREET/APT # / CITY / STATE / ZIP CODE) GENDER: ☐ MALE ☐ FEMALE

**SECONDARY** INSURANCE COMPANY: _____ SUBSCRIBER'S ID/ OR SS#: _____

POLICY HOLDER NAME: _____ (FIRST / MIDDLE / LAST) DATE OF BIRTH: _____

PHONE: _____ PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY : _____

ADDRESS: _____ (STREET/APT # / CITY / STATE / ZIP CODE) GENDER: ☐ MALE ☐ FEMALE

GAURANTOR: _____ DATE OF BIRTH: _____ ☐ CHECK HERE IF UNINSURED (SELF PAY)

**MEDICARE PATIENTS ONLY**

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO ANY CARRIER OR THE SOCIAL SECURITY ADMINISTRATION AND CMS OR ITS INTERMEDIARIES ANY INFORMATION NEEDED FOR THIS OR 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 TO THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. ***PLEASE INITIAL**: _____

## RELEASE OF MEDICAL INFORMATION

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

## VISIT

REASON FOR YOUR VISIT TODAY? : _____

HOW LONG HAVE YOU HAD THIS PROBLEM? : _____

SYMPTOMS: _____

TREATMENTS YOU HAVE TRIED: _____

## MEDICAL HISTORY

**HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING**

- ☐ ALLERGY SYMPTOMS
- ☐ BLISTERS
- ☐ BRUISING
- ☐ DRYNESS
- ☐ FEVER
- ☐ HIVES
- ☐ ITCHING
- ☐ KELOID
- ☐ RASH
- ☐ RECURRENT INFECTION
- ☐ SUSPICIOUS LESION
- ☐ WEIGHT CHANGE

HAVE YOU HAD SKIN CANCER : ☐ YES ☐ NO

**IF YES** : ☐ MELANOMA ☐ BASAL CELL CARCINOMA ☐ SQUAMOUS CELL CARCINOMA ☐ YES, BUT I DON'T KNOW WHAT TYPE

LOCATIONS : _____

DO YOU HAVE ANY FAMILY HISTORY OF SKIN CANCER : ☐ YES ☐ NO

IF YES, WHO AND WHAT TYPE : _____

**MARK ANY OF THE FOLLOWING DISEASES THAT YOU HAVE HAD:**

**GENERAL**

- ☐ ARTIFICIAL HEART VALVES
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLEEDING DISORDER
- ☐ BLOOD CLOTS
- ☐ CANCER _____
- ☐ DEPRESSION
- ☐ DEMENTIA
- ☐ DIABETES MELLITUS 1
- ☐ DIABETES MELLITUS 2
- ☐ EPILEPSY
- ☐ HAY FEVER
- ☐ HEART DISEASE
- ☐ HEPATITIS A - B - C
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ MENTAL / ANXIETY DISORDER
- ☐ PACEMAKER
- ☐ SEASONAL ALLERGIES
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ OTHER _____

**SKIN**

- ☐ ACNE
- ☐ ACTINIC KERATOSES
- ☐ ALOPECIA/ HAIRLOSS
- ☐ DERMATITIS
- ☐ DYSPLASTIC MOLE
- ☐ ECZEMA
- ☐ GENITAL WARTS
- ☐ HERPES
- ☐ HIVES
- ☐ ITCHING
- ☐ PSORIASIS
- ☐ ROSACEA
- ☐ SCABIES
- ☐ SHINGLES
- ☐ VITILIGO
- ☐ WARTS

LIST ANY SURGERY YOU HAVE HAD IN THE LAST 2 YEARS : _____

## MEDICATIONS

LIST ALL MEDICATIONS PRESCRIBED AND OVER THE COUNTER YOU ARE CURRENTLY TAKING:

_____

## ALLERGIES

LIST ANY MEDICATIONS/PRODUCTS YOU ARE ALLERGIC TO: _____

MARK ANY YOU HAVE HAD AN ALLERGIC REACTION TO : ☐ LATEX ☐ LIDOCAINE ☐ EPINEPHRINE ☐ IODINE ☐ ADHESIVES

## OTHER

FORMER SMOKER ☐ YES ☐ NO TOBACCO USE ☐ YES ☐ NO ALCOHOL USE ☐ YES ☐ NO

***FEMALE PATIENTS ONLY***

ARE YOU PREGNANT? ☐ YES ☐ NO ARE YOU BREASTFEEDING? ☐ YES ☐ NO ARE YOU TRYING TO CONCEIVE? ☐ YES ☐ NO

## FINANCIAL POLICY & ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, DIRECTLY TO **LONE PINE DERMATOLOGY**. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, AND FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS, EVEN IF SERVICES ARE DEEMED AS *NON-MEDICALLY NECESSARY" BY MY INSURANCE CARRIER. **I UNDERSTAND CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.** I AM RESPONSIBLE FOR PROVIDING CORRECT/UPDATED INSURANCE SO THIS OFFICE CAN BILL MY INSURANCE. I AUTHORIZE **LONE PINE DERMATOLOGY** TO RELEASE ANY INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. IN THE EVENT THAT PAYMENT IN FULL FOR CHARGES ARE NOT MADE, I AGREE TO PAY FOR ALL COSTS OF COLLECTION INCLUDING A COLLECTION FEE AND COURT COSTS.

_____

PATIENT OR PATIENT'S REPRESENTATIVE SIGNATURE DATE