



## 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 \_\_\_\_\_  
 Email \_\_\_\_\_ Marital Status S [ ] M [ ] D [ ] W [ ]  
 How did you hear about us? \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_  
 Employer \_\_\_\_\_

### Insurance Information

1) Insurance Co \_\_\_\_\_ 2) Insurance Co \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Subscriber Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 SS# or ID# \_\_\_\_\_ SS# or ID# \_\_\_\_\_  
 Insured's Date of Birth \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer \_\_\_\_\_

### Responsible Party

(MUST be completed if patient is a minor)

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 Hamblin Dermatology. 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 is given to Hamblin Dermatology.

(5) I agree to indemnify, defend and hold Hamblin Dermatology harmless from any loss, damages, costs, or expenses in connection with false insurance information provided by patient.

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_



**History and Intake Form**

**Reason For Today's Visit:** \_\_\_\_\_

**Past Medical History**

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

**Past Surgical History:** (Please list any surgeries within the past five years)

\_\_\_\_\_

**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	Y/N
		If YES, was any imaging done related to the melanoma?	Y/N		

Do you currently wear sunscreen? Y/N      SPF \_\_\_\_\_      Do you currently use tanning beds? Y/N

Do you have a FAMILY history of any skin cancer? Y/N      Who? \_\_\_\_\_      What type? \_\_\_\_\_

**Medications:** (Please enter all current medications and their dosage and frequency) **Select if no medications**  NONE

\_\_\_\_\_

**Drug Allergies:**(Please enter all allergies and reactions experienced )**Select if no Drug Allergies:**  NONE

**Please list drug and the reaction:** \_\_\_\_\_

**If marked Y for Melanoma: When was it treated?** \_\_\_\_\_ **Where was it located on the body?** \_\_\_\_\_

**Social History:**

Currently smokes Y/N      Drinks Alcohol Y/N      Last Flu Shot \_\_\_\_\_ N/A

Former Smoker Y/N      Drinks per Week \_\_\_\_\_      Pneumonia Vaccine Y/N



**Do you have the following?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Power of Attorney (Surrogate Decision Maker) | <input type="checkbox"/> Living Will (Advance Care Plan) | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Home Health                                  | <input type="checkbox"/> Hospice                         | <input type="checkbox"/> None                     |

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

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 2 yrs.)	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, 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	Joint Aches	Y/N	Varicose Veins	Y/N
Problems Healing	Y/N				
Other:					

Are you interested in Cosmetic or Aesthetic Services (Lasers, Fillers, Injectables, Peels, Product, etc.)? Y/N  
Which Specific Service? \_\_\_\_\_



## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, \_\_\_\_\_, have been offered a copy of the Hamblin Dermatology  
Notice of Privacy.

\_\_\_\_\_  
Patient Signature (or Guardian)                      \_\_\_/\_\_\_/\_\_\_\_\_  
Date

**\*For a copy of our HIPAA guidelines please ask the receptionist\***

### **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 is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

**Home Phone**

\_\_\_\_\_ O.K. to leave a detailed message?

**Mobile Phone**

\_\_\_\_\_ O.K. to leave a detailed message?

\*Cell number you can be reached on \_\_\_\_\_

**Work Phone**

\_\_\_\_\_ O.K. to leave a detailed message?

**Spouse/Other & Relation**

\_\_\_\_\_ O.K. to leave a detailed message and disclosing  
confidential medical information.

Please note; you have the right to review the Notice of Privacy Practices which provides information about how Hamblin Dermatology may use and disclose your personal health information (PHI). You may also revoke or change your consent in writing at any time.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

Printed Name of Guardian and  
Relationship to Patient (if applicable): \_\_\_\_\_

## 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 apologize in advance for any unforeseeable delay you may experience. We will call to confirm 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 cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, labs, or other charges. Currently, we file claims for Aetna/Cofinity, AHCCCS, AZ Foundation, BCBS – AZ, Cigna, Coventry/First Health, Health Net, HCA/HCG, Health Choice, Humana, Medicare, Multiplan/RAN, United Health Care; Commercial & Medicare Solutions, Community & State 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 and Discover. 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. In the event we are unable to answer your call immediately, please provide a return phone number where you can be reached. In case of an emergency, please dial 911 first.

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

**Referring Physicians** & possibly other physicians will be updated of your care unless you **circle:** Do Not Update

**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): \_\_\_\_\_

(\*\*\*ADMINISTRATION WILL PROVIDE FOR THE OFFICE PORTAL\*\*\*)

User Name \_\_\_\_\_

Password \_\_\_\_\_