Dermatology CONSULTANTS

Welcome to Dermatology Consultants

Chart/Acct Number _____

Patient's Name:_____ SSN: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Telephone: ( ) _____ Cell Phone: ( ) _____
Birthdate: _____ Age: _____ □ Male □ Female Marital Status: S M D W Race _____
Occupation: _____ Preferred Language:_____ Hispanic or Latino: □Yes □No
Employer: _____ Work Phone: ( )_____ Ext _____
Employer's Address: _____ City: _____ State: ____Zip:_____
Email Address: _____

Spouse's Name:_____
Spouse's SSN: _____ Spouse's Birthdate: _____
Spouse's Home address (if different) _____
City: _____ State: _____ Zip: _____
Home Telephone: ( ) _____ Cell Phone: ( ) _____
Employer: _____ Work Phone: ( )_____ Ext _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

Complete this section only if someone other than the patient is financially responsible

Responsible Party:_____ Relationship to Patient: _____
SSN: _____ Birthdate: _____
Home address (if different) _____
City: _____ State: _____ Zip: _____
Home Telephone: ( ) _____ Cell Phone: ( ) _____
Employer: _____Work Phone: ( )_____Ext _____
Employer's Address: _____
City: _____ State: _____Zip: _____

Medical History

Please respond in all spaces and attach separate sheet if needed.

Current Medications: Please use provided ***Medicine Chart*** to list current prescriptions and over the counter medications.
Preferred Pharmacy:_____ Location:_____
Drug Allergies: □ No known allergies □ Yes If Yes, please list_____

_____

Are you allergic to Latex? □ Yes □ No **Pacemaker?** □ Yes □ No Pregnant □ Yes □ No
Medical Problems (answer yes or no) Diabetes _____ Heart Disease _____ High Blood Pressure_____
Bleeding or Anemia _____ Other Medical Problems:_____

_____

Do you have a **personal history of Melanoma?** □ No □ Yes If yes, location _____
Family history of Melanoma? □ No □ Yes If Yes, Relationship to patient _____
Were you referred by another doctor? _____ Doctor's name:_____
What brings you to see the doctor today?_____

Patient's Name _____ Chart # _____

Insurance Information:

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers.

Primary Insurance:
Name of Insurance Company: _____
Address of Insurance Company: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Insured's Birthdate: _____ Insured's SSN _____
Policy ID Number: _____ Group Number _____

Secondary Insurance:
Name of Insurance Company: _____
Address of Insurance Company: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Insured's Birthdate: _____ Insured's SSN _____
Policy ID Number: _____ Group Number _____

I agree that I am responsible for any non-covered services, co-pays and deductibles at time of service. If unable to pay in full at that time, I will need to make payment arrangements. Should my account become delinquent and need to be assigned to a collection agency, I agree to pay all collection agency fees, court costs and/or attorney fees. I also agree, in order for us to service our account or to collect any amounts you owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/we have read this disclosure and agree that the Lender/Creditor may contact me/us as described above. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated agreement by me or my responsible party.

_____ _____ _____
Patient/Responsible Party Signature Printed Name Date

I authorize the release of any medical information necessary to process my claim. I also authorize payment of medical and surgical benefits to Dermatology Consultants, Inc.

_____ _____ _____
Patient/Responsible Party Signature Printed Name Date

Who is your primary care physician?_____
Physician's address:_____
Physician's phone number:_____
How did you learn about our practice? _____

For more information about our practice please visit our new website www.lynchburgdermatology.com 5/16