ILLINOIS DERMATOLOGY INSTITUTE

Date:____/_____/_____

PATIENT INFORMATION

Name: _____
Last First M.I.

Mailing Address:_____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone:_____

OK to leave message: ☐ Yes ☐ No **OK to leave message: ☐ Yes ☐ No** **OK to leave message: ☐ Yes ☐ No**

Date of Birth: _____/_____/_____ S.S.N. _____/_____/_____ Marital Status: _____ Spouse Name: _____

Age: _____ Sex: _____ Employment: ☐ FT ☐ PT ☐ FT-Student ☐ PT-Student ☐ Retired ☐ Unemployed

Email Address: _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Last
First M.I.

Mailing Address:_____
Street City State Zip Code

Home Phone: _____ Work Phone: _____Cell Phone:_____

Date of Birth: _____/_____/_____ S.S.N. _____/_____/_____Age: _____ Sex: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: ____/_____/_____ Relationship to patient: _____

☐ HMO (Referral Required) ☐ PPO ☐ Out of Network

Secondary Insurance Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: ____/_____/_____ Relationship to patient: _____

☐ HMO (Referral Required) ☐ PPO ☐ Out of Network

☐ **Self-Pay**

In selecting Self-Pay, you are waiving your right to have your insurance company billed for any non-cosmetic Services (see patient responsibility policy).

In case of Emergency, who should be notified? _____Phone: _____

Can we discuss your medical conditions with other members of your household? ☐ Yes ☐ No Specify: _____

Referred By: ☐ Physician _____ ☐ Family/Friend _____

How did you hear about us? ☐ Family/Friend ☐ Internet ☐ Advertisement ☐ Insurance Referral ☐ Other _____

I authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected. We accept payment in the form of cash or credit card. If we do accept a check for payment, and the check does not clear the bank, a $25.00 service fee will automatically be added to your account. Please note that any procedure performed in the office may be billed separately in addition to the office visit fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/Responsible Party Signature: _____Date: _____/_____/_____

Name: _____Relationship to patient: _____

Please check all the following boxes that apply:

Past Medical History

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation (irregular heartbeat)
- □ BPH (enlarged prostate)
- □ Bone Marrow Transplant
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ End Stage Renal Disease
- □ GERD (Gastric Reflux)
- □ Hearing Loss
- □ Hepatitis
- □ Hypertension
- □ HIV/AIDS
- □ Hypercholesterolemia
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ Other:_____
- □ ***No Past Medical Problems***

Past Surgeries

- □ Appendix (Appendectomy)
- □ Bladder (Cystectomy)
- □ Breast: Mastectomy (Right Breast)
- □ Breast: Mastectomy (Left Breast)
- □ Breast: Mastectomy (Both Breasts)
- □ Breast: Lumpectomy (Right Breast)
- □ Breast: Lumpectomy (Left Breast)
- □ Breast: Lumpectomy (Both Breasts)
- □ Breast: Breast Biopsy
- □ Breast: Breast Reduction
- □ Breast: Breast Implants
- □ Colon (Colectomy): Colon Cancer Resection
- □ Colon (Colectomy): Diverticulitis
- □ Colon (Colectomy): Inflammatory Bowel Dz
- □ Gallbladder (Cholecystectomy)
- □ Heart: Coronary Artery Bypass Surgery
- □ Heart: PTCA (angioplasty)

Past Surgeries Continued

- □ Heart: Mechanical Valve Replacement
- □ Heart: Biological Valve Replacement
- □ Heart: Heart Transplant
- □ Joint Replacement: Knee (Right)
- □ Joint Replacement: Knee (Left)
- □ Joint Replacement: Knee (Both)
- □ Joint Replacement: Hip (Right)
- □ Joint Replacement: Hip (Left)
- □ Joint Replacement: Hip (Both)
- □ Kidney: Kidney Biopsy
- □ Kidney: Nephrectomy (Kidney Removal)
- □ Kidney: Kidney Stone Removal
- □ Kidney: Kidney Transplant
- □ Ovaries (Oophorectomy): Endometriosis
- □ Ovaries (Oophorectomy): Ovarian Cyst
- □ Ovaries (Oophorectomy): Ovarian Cancer
- □ Prostate (Prostatectomy): Prostate Cancer
- □ Prostate (Prostatectomy): Prostate Biopsy
- □ Prostate (Prostatectomy): TURP
- □ Skin: Skin Biopsy
- □ Skin: Basal Cell Carcinoma Surgery
- □ Skin: Squamous Cell Carcinoma Surgery
- □ Skin: Melanoma Surgery
- □ Spleen (Splenectomy): Spleen Removal
- □ Testicles (Orchidectomy): Testicle Removal
- □ Uterus (Hysterectomy): Fibroids
- □ Uterus (Hysterectomy): Uterine Cancer
- □ Other:_____
- □ ***No Past Surgical Procedures***

Skin Disease History

- □ Acne
- □ Actinic Keratoses (precancers)
- □ Asthma
- □ Basal Cell Skin Cancer
- □ Blistering Sunburns
- □ Dry Skin
- □ Eczema
- □ Flaking or Itchy Scalp
- □ Hay Fever/Allergies
- □ Melanoma
- □ Poison Ivy
- □ Precancerous Moles
- □ Psoriasis
- □ Squamous Cell Skin Cancer
- □ ***No Past Skin Problems***

Skin History

Do you wear sunscreen?

- □ Yes. What SPF do you apply?_____
- □ No

Do you tan in a tanning salon?

- □ Yes
- □ No

Family History

Is there a family history of melanoma?

Mother	□ Yes □ No
Father	□ Yes □ No
Sibling	□ Yes □ No
Grandmother	□ Yes □ No
Grandfather	□ Yes □ No

Medications

With your permission, we can obtain prescription information directly from your pharmacy?

□ **Yes** □ **No (if no, please list all below)**

If yes, please list **non-prescription** medications below:

1. _____
2. _____
3. _____

Injectable Medications:

1. _____
2. _____

□ ***No Current Medications***

Allergies: (Please list all allergies)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

□ **No Drug Allergies**

Sexual History

- □ Not sexually active
- □ Sexually active with one partner
- □ Sexually active with two or more partners
- □ Same gender partner

Drinking Alcohol History

- □ No alcohol
- □ Less than 1 drink per day
- □ 1-2 drinks per day
- □ 3 or more drinks per day

Smoking History

- □ Currently smokes daily
- □ Currently smokes but not daily
- □ Former smoker
- □ Has never smoked

Family History of Disease

- □ Yes
- □ No

Relative and Disease

_____

Relative and Disease

_____

Review of Systems *Have you recently experienced any of the following:*

- □ Changing , bleeding or itching mole/lesion
- □ Rash
- □ Itching
- □ Burning Skin
- □ Fever/Chills
- □ Unintentional Weight Loss
- □ Night Sweats
- □ Muscle Weakness
- □ Joint Aches
- □ Neck Stiffness
- □ Headaches
- □ Seizures
- □ Blurry Vision
- □ Chest Pain
- □ Shortness of Breath
- □ Cough
- □ Sore Throat
- □ Abdominal Pain/Nausea/Vomiting
- □ Bloody Stool
- □ Depression
- □ Hay Fever
- □ Problems Healing
- □ Burning with urination
- □ Heat or cold intolerance
- □ Frequent nose bleeds
- □ ***Does not apply***

Alerts

- □ Defibrillator
- □ Pacemaker
- □ Artificial Joint Placed in Last 2 Years
- □ Artificial Heart Valve
- □ Antibiotic Prophylaxis
- □ History of Scarring (Keloid)
- □ History of Passing Out (Vasovagal)
- □ Organ Transplant Recipient
- □ Immunosuppressed (Low Immunity)
- □ Allergy to Adhesive
- □ Pregnant or Planning a Pregnancy
- □ Breast Feeding
- □ Stomach Upset with Antibiotics
- □ Yeast Infection with Antibiotics
- □ Allergy to Topical Antibiotics
- □ Anti-coagulated (on blood thinners)
- □ Allergic to Lidocaine
- □ Rapid Heart Beat with Epinephrine
- □ HIV/AIDS
- □ Hepatitis C
- □ History of MRSA
- □ ***Does not apply***

Vaccines

Have you ever had the pneumonia vaccine?

- □ Yes
- □ No

Female Patients Only

Are you pregnant?

- □ Yes Due Date_____
- □ No

Are you breast feeding?

- □ Yes
- □ No

Are you trying to get pregnant?

- □ Yes
- □ No

Primary Care Physician

_____

Phone_____

Address_____

Prescription Coverage

- □ Yes
- □ No

Preferred Pharmacy _____

Phone_____

Zip code_____

Preferred Language

- □ English
- □ Other:_____

Race

- □ White
- □ American Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or other Pacific Islander
- □ Other Race:_____

Ethnic Group

- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Unknown

The notice of privacy practice for the office of Illinois Dermatology Institute, LLC is available at the front desk and on our website at www.illinoisderm.com. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at any time by calling our office to request a copy or mailing a written request.

Section 1 of this document provides your acknowledgement that you have read our Notice of Privacy Practices.

Section 2 requests your response to notification format and designation of a family member or other designee that we may contact and discuss your medical care in the event of an emergency or for the purpose of the individual items as checked below.

Section 3 provides the opportunity to opt in or opt out of receiving marketing communication from our office.

Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office Illinois Dermatology Institute, LLC

_____ _____

Patient Name *Date*

_____ _____

Date of Birth ***MRN (Office Use)***

Section 2 – Notification and Emergency Designee

I give permission to Illinois Dermatology Institute, LLC (IDI) and staff to perform the following duties in effort to maintain continuity of care.

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.

☐ **YES** ☐ **NO**

Leave a message of normal test result on my home answering machine or with a specified family member.

☐ **YES** ☐ **NO**

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

_____

Designated Person *Contact Number*

Section 3 – Marketing communication

IDI would like to share **new product, discounts or service information directly to you**, our patient. The information may be communicated by phone call, text, letter, or email. **(You are able to change your decision at any time by notifying our office.)**

☐ **I wish to opt IN** Email Address

_____

☐ **I wish to opt OUT I do not** wish to receive marketing information.

I understand the information provided to me in the privacy notice and I have indicated my response to questions in each section.

Patient Signature _____ *Date*_____

Phone # _____

ILLINOIS DERMATOLOGY INSTITUTE

Patient Responsibility Policy

1. It is the patient's responsibility to check to see if we are in-network.

2. If you have an HMO insurance, you are responsible for your referrals. Referrals are only valid for 90 days from the issue date and are only good for as many visits as your primary doctor has approved.

3. You are responsible for knowing the policies of your insurance, such as: co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc.

4. Co-pays and Self-pay procedures are due at the time of service, no exceptions.

5. Self-Pay patients are required to pay at the time of service. It is the patient's responsibility to update the office on any changes to your insurance coverage. Should you notify the office of an insurance status change, we will attempt to submit the claim with the updated information. If this request occurs after the timeframe allowed with your insurance company or you do not have the necessary referral or prior authorization, you will be financially responsible for any balance due on your account.

6. If you need to cancel and/or reschedule an appointment, please notify the office 24 hours in advance. If you cancel in less than 24 hours or no show to your appointment, you will be charged a $50 fee.

7. If you need to cancel and/or reschedule a cosmetic/surgical appointment, please notify the office 24 hours in advance. If you cancel in less than 24 hours or no show to your appointment, you will be charged a $100 fee.

8. For the consideration of our patients who want to be seen, if you repeatedly cancel less than 24 hours in advance or no show your appointment, we have the right to discharge you as a patient.

9. Please call the office if you are going to be late to your appointment. It will be up to the discretion of the provider if you will be seen if you arrive more than 15 minutes late.

10. All cosmetic procedures are elective, done at the expense of the patient and payment is due in full at the time of service. Cosmetic consultations are subject to a $75 fee. Cash or credit cards are acceptable methods of payment. We will not accept personal checks.

11. ANY product purchased from our office cannot be returned even if not opened.

12. The office will be collecting a deposit for any surgical procedures that approximates the contracted rate with managed care plans. If a patient has reached or exceeded a deductible/out-of-pocket maximum, a refund will be issued in a reasonable time period.

13. The office will collect a credit card (encrypted/protected) on file in the event there is a balance after processing of insurance. In the event the patient or responsible party does not pay the bill in full or have a documented conversation with the billing department regarding a mutually agreed upon payment plan, the card will be automatically charged 60 days after the bill is sent out.

I have read and understand the patient responsibility policy of Illinois Dermatology Institute, LLC.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____