SUNRISE DERMATOLOGY

Dependent Intake Form

Demographic Information

Last name _____ First name _____ MI _____

Date of Birth _____ Sex _____ Social Security No. _____

Mailing Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

May we leave a detailed voicemail? □ Yes □ No If yes, at which phone number listed? □ Home □ Cell □ Work

Responsible Party Name _____DOB _____

Responsible Party Social Security No._____Contact Number_____

Responsible Party Address (if different from above)_____

Email address _____

Would you like to pay your bill online and access your statements? □ Yes □ No If yes, an email will be sent to you.

May we add you to our email list? □ Yes □ No Would you like to be added to the Solé MedSpa email list? □ Yes □ No

Emergency Contact Information

Name _____ Relationship _____ Phone number _____

Name _____ Relationship _____ Phone number _____

Referral Information

Were you referred by another physician? □ Yes □ No If yes, please list physician name: _____

Primary Care Physician _____ Phone number _____

Insurance Information (Please notify front desk of additional insurance plans.)

Primary:

Insurance Company _____ Policy No. _____ Group No. _____

Policyholder Name _____ Policyholder DOB _____ Policyholder SSN _____

Secondary:

Insurance Company _____ Policy No. _____ Group No. _____

Policyholder Name _____ Policyholder DOB _____ Policyholder SSN _____

Pharmacy Information

Name _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

By signing below, I certify that the above information is correct. I will contact Sunrise Dermatology immediately with any change.

Signature _____ Date _____

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Medical History Form

Patient Name: _____Preferred Name: _____Date of Birth: _____

Date:_____Reason for Today's Visit:_____

Past Medical History

Do you currently have, or have you ever been diagnosed with, any of the following conditions? (Check if Yes)

□ Anxiety	□ COPD	□ Hepatitis B or C	□ Leukemia
□ Arthritis	□ Coronary artery disease	□ High blood pressure	□ Lung Cancer
□ Asthma	□ Depression	□ HIV/AIDS	□ Prostate cancer
□ Atrial fibrillation	□ Diabetes	□ High cholesterol	□ Radiation treatment
□ Bone marrow transplant	□ Kidney disease	□ Hyperthyroid (high)	□ Seizures
□ Breast cancer	□ GERD/Acid reflux	□ Hypothyroid (low)	□ Stroke
□ Colon cancer	□ Hearing loss	□ Lymphoma	□ **None of these**

Other medical problems not listed above:_____

List any major surgeries: _____

Skin Disease History

Have you ever had skin cancer? □ Yes □ No □ Not Sure
If yes, which type(s), and what year(s)? □ Basal Cell _____ □ Squamous Cell _____ □ Melanoma _____ □ Not sure
Have you ever used a tanning bed? □ Yes □ No Do you use sunscreen? □ Yes □ No
Do any of your blood relatives have melanoma? □ Yes □ No Relationship: _____

List all current medications:_____
_____

List any allergies to medication:_____

Social History

Do you smoke? □ Yes □ No If yes, how many packs per day? _____ □ Former smoker
Do you drink alcohol? □ Yes □ No If yes, how many drinks per day? _____

Are you up to date on immunizations?
Yearly flu vaccine: □ Yes □ No Pneumonia: □ Yes □ No Shingles: □ Yes □ No

Review of Systems: Are you currently experiencing any of the following? (Check if Yes)

□ Problems with healing	□ Weight changes	□ Shortness of breath	□ Numbness or tingling
□ Excessive scarring (keloid)	□ Headaches	□ Abdominal pain	□ Intolerance to hot/cold
□ Problems with immune system	□ Vision changes	□ Changes in stool	□ Mood changes
□ Easy bruising or bleeding	□ Sore throat	□ Changes in urine	□ Other: _____
□ Fever or chills	□ Chest pain	□ Joint pain	□ **None of these**

Additional questions:

Have you had a reaction to local anesthesia? □ Yes □ No Are you allergic to adhesive? □ Yes □ No
Have you had a reaction to epinephrine? □ Yes □ No Are you on blood thinners? □ Yes □ No
Do you have an artificial heart valve? □ Yes □ No Do you have artificial joints? □ Yes □ No
Do you have a pacemaker? □ Yes □ No Do you have a defibrillator? □ Yes □ No
Have you been told to take antibiotics prior to dental or surgical procedures? □ Yes □ No
Are you pregnant/planning pregnancy? □ Yes □ No If pregnant, due date: _____
Are you breastfeeding? □ Yes □ No

SUNRISE DERMATOLOGY
FINANCIAL & OFFICE POLICIES

Thank you for choosing our practice. We appreciate your trust in us and the opportunity to serve you. As a part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment.

- Payment for non-covered or cosmetic procedure is due at the time of service.
- We accept cash, check, or credit cards (Visa, Master Card, Discover)
- A 35% service charge will be added to bills over 30 days old.
- We offer an extended payment plan for patients meeting low income or financial hardship criteria.
- There is a $35.00 charge for returned checks.
- **We require 24 hours prior notice to cancel or reschedule an appointment.** Failure to notify us of the cancellation will result in a cancellation fee of $50.00 for an office visit and $150.00 for a surgery appointment.

PARTICIPATING PLANS:
We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for any balance due. **Co-pay and deductibles are to be paid on the date of service.**

MEDICARE:
We participate with Medicare and accept assignment. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance. We will file a claim with your secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, the patient may be billed.

NON-PARTICIPATING PLANS:
As a courtesy to you we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the balance will be assessed for payment. You should remit payment within 30 days or contact your insurance company to check on the status of the claim. Please notify us immediately upon contacting your insurance company or if there is anything, we can do to help settle this claim. The Sunrise Dermatology Mobile, AL location does not participate in Medicaid or State of Alabama Medicaid plans.

OUTSIDE PATHOLOGY OR LABORATORY SERVICES:
If the expertise of an outside lab is needed for a portion of your care (biopsy interpretation, second opinion) you may receive a separate bill from that lab for their services.

USUAL AND CUSTOMARY RATES:
Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

_____ I have read, understand and agree to this Financial Policy.

_____ I request that payment of authorized Medicare and/or the insurance carrier be made either to me or on my behalf to Sunrise Dermatology for any services furnished to me. I authorize any holder of medical information about me to release to Sunrise Dermatology and its agents and/or other insurance carrier any information needed to determine benefits payable for services.

_____ I understand that it is my responsibility to notify Sunrise Dermatology in writing of any changes to this release of information consent.

_____ I acknowledge that I have read and understand the Notice of Privacy Practices including Patient Bill of Rights and that I can obtain a copy upon request. I understand further that Sunrise Dermatology and its business associates (including its billing company) may use or disclose my health information in communications with third parties who are involved in or indicate that they are responsible for payment for my healthcare services. I understand that such third parties might include persons who are the policy holders of any policy of insurance covering me. I acknowledge that I am entitled to prevent these communications by objecting to them, and by my signature below, indicate that I DO NOT OBJECT to such communications.

DESIGNATION OF PERSONS TO WHOM WE MAY DISCLOSE YOUR RECORDS IN YOUR ABSENCE:

1. _____ 2._____

3. _____ 4. _____

(You may also call us or personally inform us at any time of persons to whom we may disclose your records.)

Print Name of Patient: _____Patient's Date of Birth: _____ Date: _____

Patient or Personal Representative Signature: _____

Relationship of Representative (parent, guardian, etc.): _____