

**Philadelphia Institute of Dermatology**

**Patient Medical History Form**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

Have you had skin cancer(s) in the past?: Yes/No  
Have you ever had a blistering sunburn?: Yes/No  
Do you have any relatives with skin cancer?: Yes/No  
Are you pregnant or trying to become pregnant? Yes/No

**Past Medical History (Circle "Yes" or "No" if you have or had any of the following):**

Heart Disease	Yes/No	Diabetes	Yes/No
Artificial Heart Valve	Yes/No	High Blood Pressure	Yes/No
Heart Murmur	Yes/No	Bleeding disorder	Yes/No
Lung Disease	Yes/No	Healing Problems	Yes/No
Liver Disease	Yes/No	Keloids	Yes/No
Stroke	Yes/No	Pacemaker	Yes/No
Dementia	Yes/No	Defibrillator	Yes/No
Cancer	Yes/No	Joint Replacement	Yes/No
Hepatitis B or C	Yes/No	HIV/AIDS	Yes/No

Do you take antibiotics before dental visits? Yes/No

Other medical problems: \_\_\_\_\_

Do you take: Aspirin? Yes/No Plavix? Yes/No Coumadin? Yes/No

Please list any allergies you have to medications or tape: \_\_\_\_\_

**Please list all other medications you are currently taking:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use tobacco? Yes/No If yes, how much? \_\_\_\_\_

Do you use alcohol? Yes/No If yes, how much? \_\_\_\_\_

**Pharmacy Prescription Card:**

(Staff will insert a copy of your insurance card in this area)

The American Academy of Dermatology recommends a full body screening annually

Today's Date \_\_\_\_\_ Circle: Male or Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Marital Status: M \_ S \_ D \_ W \_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone:( ) \_\_\_\_\_ Work Phone:( ) \_\_\_\_\_ Cell Phone:( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Please circle the preferred phone line to receive your biopsy/test results and confirmation calls: work, home, cell

Emergency Contact: Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRIMARY INSURANCE :**

Who is the primary card holder of your insurance?

Subscriber's relationship to the patient: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_ Subscriber's Social Security #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Circle: M or F DOB: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Subscriber's Place of Employment: \_\_\_\_\_ Subscriber's work phone : \_\_\_\_\_

---

**SECONDARY INSURANCE :**

Subscriber's relationship to the patient: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_ Subscriber's Social Security #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Circle: M or F DOB: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Subscriber's Place of Employment: \_\_\_\_\_ Subscriber's work phone: \_\_\_\_\_

**Philadelphia Institute of Dermatology  
Financial Policy & HIPAA Consent**

**It is imperative that a current copy of your insurance card is provided for accurate billing. Every patient's insurance policy is different and it is beyond the ability of our staff to know the benefits of every plan. Our office can never guarantee coverage for any service provided by our office. If you are unsure of your coverage benefits, call the customer service number on your insurance card.**

**Return check fee \$30.00**

**Labs:** Our office utilizes some outside facilities for blood work, biopsies, cultures, etc. Insurance and/or billing are handled separately by these facilities. You will receive a separate explanation of benefits from your insurance carrier. You may also receive a separate bill from the lab, depending on the benefits of your plan.

**Medicare patients:** We are participating providers of the Medicare part B program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the copayment. Our office will file your secondary/supplemental carrier claims. However, in the event that the secondary does not pay, patients will be billed for the balance.

**Medicare Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a 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 either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**Supplemental Authorization: (Medicare patients)**

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

**HMO, POS, PPO, Commercial or other managed care patients:** You will be responsible for paying your annual deductible, copayment, coinsurance and charges for any non-covered, cosmetic services or over-the-counter products at the time of the visit. If your health plan requires a referral for specialty services, you will need to obtain one before your date of service. If a valid referral is not received by your appointment time, you will be expected to pay for the office visit.

**Self-Pay:** Payment is required at the time of service.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service (e.g., deductibles, copayments, and non-covered services).

Our collection agency will handle any outstanding account over 60 or 90 days.

Please advise our Billing Dept. (x229) on any changes of names, address or insurance.

If you need to cancel or change an appointment, please contact our office to do so at least 24 hours before your scheduled appointment. Less than 24 hours notice will result in a \$30.00 fee.

My signature below indicates that I have reviewed and/or have access to a copy of my physician's Notice of Privacy Practices.

I have read the financial policy, and I understand and agree to this policy.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date