PHILADELPHIA INSTITUTE OF DERMATOLOGY
Andrew K. Pollack, MD & Associates

DERMATOLOGICAL PATIENT MEDICAL INFORMATION

LAST NAME: _____FIRST NAME: _____

Have you been seen in our office before? ☐ **Y** ☐ **N**
Have you had skin cancer(s) in the past? ☐ **Y** ☐ **N**
Do you have any relatives with skin cancer? ☐ **Y** ☐ **N**
Are you pregnant or trying to become pregnant? ☐ **Y** ☐ **N**

PAST MEDICAL HISTORY (Check "Yes" or "No" if you have or had any of the following):

Heart Disease	☐ **Y** ☐ **N**	**Diabetes**	☐ **Y** ☐ **N**
Artificial Heart Valve	☐ **Y** ☐ **N**	**High Blood Pressure**	☐ **Y** ☐ **N**
Heart Murmur	☐ **Y** ☐ **N**	**Bleeding disorder**	☐ **Y** ☐ **N**
Lung Disease	☐ **Y** ☐ **N**	**Healing Problems**	☐ **Y** ☐ **N**
Liver Disease	☐ **Y** ☐ **N**	**Keloids**	☐ **Y** ☐ **N**
Stroke	☐ **Y** ☐ **N**	**Pacemaker**	☐ **Y** ☐ **N**
Dementia	☐ **Y** ☐ **N**	**Defibrillator**	☐ **Y** ☐ **N**
Cancer (other than skin)	☐ **Y** ☐ **N**	**Joint replacement**	☐ **Y** ☐ **N**
Hepatitis B or C	☐ **Y** ☐ **N**	**HIV/AIDS**	☐ **Y** ☐ **N**

Other medical problems: _____

_____

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING (write on back if room needed):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take: Aspirin? ☐ Y ☐ N - Plavix? ☐ Y ☐ N - Coumadin? ☐ Y ☐ N - Other_____

Please list any allergies you have to medications or tape: _____

_____

Do you use tobacco? ☐ **Y** ☐ **N** **If yes, how much? _____**
Do you use alcohol? ☐ **Y** ☐ **N** **If yes, how much ?_____**

BIOPSY/HEALTH CARE RESULTS:

I authorize the Philadelphia Institute of Dermatology to **leave a message** containing biopsy results at the following phone number: _____

AUTHORIZED PERSON:

☐ **NO ONE** is authorized to access my private HEALTH/BILLING information.
☐ **I AUTHORIZE** the following person to have access to my private HEALTH/BILLING information:

Authorized Person's Name _____Phone_____

Patient's Signature _____Date_____

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PATIENT INFORMATION -- PLEASE PRINT LEGIBLY **TODAY'S DATE:_____**
PLEASE FILL OUT ALL FIELDS – USE "NA" WHEN NOT APPLICABLE

Last Name:_____ First Name:_____ SSN:_____

Sex(Circle): Male or Female Marital Status: M___ S___ D___ W___ Date of Birth: ____/____/____

Race: _____ Hispanic (Circle): Y or N

Street Address: _____ City: _____State: _____ Zip Code: _____

Primary Phone: ( ) _____ Secondary Phone: ( ) _____

Work Phone: ( ) _____ Email Address: _____@_____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Subscriber's Sex(Circle): Male or Female

Subscriber's Last Name:_____ First Name:_____

Address(if different from Patient) _____

Date of Birth: ____/____/____ Relationship to Patient (Circle): Self Spouse Parent StepParent Other_____

ID #: _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Subscriber's Sex(Circle): Male or Female

Subscriber's Last Name:_____ First Name:_____

Address(if different from Patient) _____

Date of Birth: ____/____/____ Relationship to Patient (Circle): Self Spouse Parent StepParent Other_____

ID #: _____ Group # _____

IF MEDICARE IS SECONDARY, PLEASE STATE WHY _____

FINANCIALLY RESPONSIBLE PARTY (*if different from patient*) e.g., Parent/ Legal Guardian/ etc.

Last Name:_____ First Name:_____ SSN:_____

Date of Birth: ____/____/____ Sex(Circle): Male or Female Relationship to Patient: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone: ( ) _____ Work Phone: ( ) _____

EMERGENCY CONTACT

Last Name:_____ First Name:_____ Relationship: _____

Contact Phone Number: ( ) _____

PRIMARY CARE DOCTOR: _____ **CITY:** _____ **PHONE: (** **)** _____

REFERRING DOCTOR: _____ **CITY:** _____ **PHONE: (** **)** _____

PHARMACY: _____ **Street Address:** _____

City: _____ **State:** _____ **PHONE: (** **)** _____

For Office Use Only—Date Ins. Cards Scanned _____

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.

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.

Return check fee: $30.00

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).

Collections: Outstanding accounts (over 90 days delinquent) will be sent to our Collection Agency and incur a 25% collection fee which will be added to the total balance.

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

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of any claims delay or unjustified reductions or denials.

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 11/7/13