PINNACLE
DERMATOLOGY

Patient Information

Please present picture ID and Insurance card

Name: ____
Last First M.I. (Preferred Name)

Address: ____
Street City State Zip

Date of Birth:________/________/________ Age: _____ Gender: M F Marital Status: S M D W

Ethnicity:________________SSN: _______________Primary Contact Number: ☐ Home ☐ Cell ☐ Work

Home: (____)______________Cell: (____)___________________Work: (_____)_____________ Ext: _____

Email:___________________________________Pharmacy & Location: ____________________________

Employer:____ Occupation: ________________

In case of emergency, notify:______________________________Phone: ___________________
Relationship

Who is your family doctor? ______________________________Phone: ___________________

I hereby authorize Pinnacle Dermatology, SC to treat my child in my absence. ____________________
Parent Signature

Insurance Subscriber (☐ Check if same as above)

Name: ____
Last First M.I. SS#

Address: ____
Street City State Zip

Work Phone: (_____)_____________Ext._______Home Phone: (______)______________________________

Cell Phone: (______)_____________Date of birth:_____/____/____Relationship to patient: _____________

Insurance Information (Please present card at time of check-in.)

Primary Insurance name:______________________Secondary Insurance name: ________________________

Policy Holder:______________________________Policy Holder: __________________________________

Contract #: _______________________________ Contract #: _____________________________________

Group #: _________________________________ Group #: _______________________________________

Relationship to patient:_______________________Relationship to patient: _________________________

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this provider for any services furnished me by this physician. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine benefits for related medical services. I authorize Medicare to furnish the above-named doctor any information regarding my medical claims under Title XVII of the Social Security Act.

Commercial Insurance

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the doctor indicated on the claim. I understand I am financially responsible for any balance not covered by insurance. I give consent for Pinnacle Dermatology, SC to communicate with my referring physician.

Patient or Guardian Signature:____**Date:** /_/_____

Name:____**D.O.B:** ____________________

What are your concerns today and when did the problem(s) begin? ______________________________

Which Pharmacy do you currently use? ______________ Phone Number ____________________

Medical History

Select any of the following medical conditions that you currently have.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other: ______________ ____________________

Past Surgical History

Select any organs that you have had previous surgeries.

- ☐ Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- NONE
- Other

Name:____**D.O.B:** ______________________

Medical History Continued

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ 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
- ☐ NONE
- ☐ Other: __________________________________

Do you use Sunscreen? ☐ Yes ☐ No If Yes, what SPF? _____Do you Tan indoor or outdoor? ☐ Yes ☐ No

Do you have a family history of Skin Cancer? ☐ Yes ☐ No If yes which relative(s)? ____________________

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes which relative(s)? ____________________

List all current medications you take or apply regularly: ____

Do you need to take antibiotics before any surgeries or dental procedures? ☐ Yes ☐ No

If yes, what____

List all allergies and reactions if known: ____

- ☐ I want my skin checked for skin cancer (Full Body Exam)
- ☐ I want my skin checked for skin cancer (Full Body Exam), and I will call at a later date to make an appointment.
- ☐ No, I do not want my skin checked for skin cancer. (Decline a Full Body Exam)

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy - ________________________________

Quit Smoking:

- mm/dd/yyyy - ________________________________

Number of Packs Per Day: __________

Total Years Smoking: ______________

Alcohol Intake (Please Choose one)

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

Name:____**D.O.B:** ____________________

Social History Continued

How often do you exercise?	What is your caffeine use?
☐ Unspecified	☐ Unspecified
☐ Several times a day	☐ Several times a day
☐ Once a day	☐ Once a day
☐ A few times a week	☐ A few times a week
☐ A few times a month	☐ A few times a month
☐ Never	☐ Never
☐ Other	☐ Other
______________________________	______________________________

Cosmetic Concerns

What are you skin care or cosmetic concerns? Please circle all that apply

Facial Concerns

Brown spots	White heads	Black heads	Sun damage
Spider veins	Yellow/stained teeth	Redness	Loss of elasticity
Loss of facial volume	Wrinkles/lines	Enlarged pores	Sensitivity
Oily skin	Excess hair	Non-matching makeup	Uneven skin texture
Dry skin	Thin lips	Scars	Other:

Body Concerns

Scars	Excessive sweating	Appearance of chest	Fragile/brittle nails
Sagging skin	Excess fat	Dry body skin	Cellulite
Stretch marks	Body acne	Sun damage	Spider veins
Thinning hair	Other:	Other:	Other:

Name:____**D.O.B:**_____________________

Medical History Review of Systems

Please circle **ALL** conditions that apply, please check **NO** if none of the conditions apply

System Review	Circle all that apply (Presently)	No	Comments/Other
Constitutional	Fevers, chills, night sweats		
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching, eczema		
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness, earache, nasal polyps, ear ringing		
Eyes	Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma		
Respiratory	Shortness of breath, asthma, difficulty breathing, emphysema, bronchitis, tuberculosis		
Cardiovascular	Heart attack, irregular heartbeat, heart murmur, chest pain, high blood pressure		
Gastrointestinal	Ulcer, hepatitis, weight changes, bowel changes, weight gain, weight loss, liver problems, intestinal disorders, reflux		
Genitourinary	Painful urination, difficulty urinating, blood in urine, renal disease/failure, frequent urination, kidney problems		
Musculoskeletal	Arthritis, weakness, back pain, joint pain, cramps, stiffness, osteoporosis		
Neurologic	Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines, myasthenia gravis		
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness		
Endocrinology	Intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue, diabetic		
Hematologic	Blood clots, anemia, bleeding problems, hepatitis, blood transfusions, platelet disorder		
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes		
Other Medical Problems	Such as: Cancers, infectious disease, HIV, autoimmune disease, etc.		

Have you had an annual flu shot? Yes:_______Date:_______________No: ________

Are you pregnant or nursing?_____Yes_____No If Yes how far along: ____________________________

Are you planning on getting pregnant?_____Yes_____No Is your menstrual cycle regular?_____Yes_____No

Have you ever taken Accutane?________If yes, for how long? ____

I consent to being tested for hepatitis / HIV (AIDS) if an office staff member is directly exposed to potentially contagious material (i.e., needle stick). **Initials:**_________**Date:** ___________

Patient or Guardian Signature:____**Date:** _______________

The Health Care Provider signature below indicates this entire form was reviewed to include: allergies · past medical history · family history · social history surgical history · medications · review of systems

Provider Signature:____Date:___________________

(Doctor, nurse practitioner, physician assistant)

Name:______________________________**D.O.B:** ____________________

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. The following information outlines your responsibility related to payment and appointment reservation for professional services. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Insurance: At each visit we must verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage.

Co-payment: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payment and co-insurance are determined by your insurance. We accept cash, check, Visa, MasterCard, American Express, Discover and Care Credit.

Deductible: An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

Credit Card on File: For any prearranged payment plans, Pinnacle Dermatology, SC will keep credit cards on file (CCOF). We do not keep any credit card information on file in the office or on any of our computers. We use a secure, encrypted gateway that is completely compliant as required by law.

Referrals: If your insurance company requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain one. If the referral is not sent to us prior to your scheduled appointment you may be asked to reschedule the visit until we have a valid referral on file. It is also your responsibility to ensure that your PCP is listed correctly with your insurance company. If the PCP is not correct at the time of service, you will be responsible to pay for the cost of services rendered.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is available for subsequent visits. All co-pays or monies due are expected to be paid at the time of each service.

Determining Guarantor: The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if they are over the age of 18. The guarantor for a minor child is the parent that presents the child for care at the time of the initial visit.

Non-Payment: If your account is 120 days past due, we will refer your account to an external collection agency. Once the account has been placed with the agency, we will add a 30% collection fee that will need to be paid in full along with the past due balance to schedule future appointments with Pinnacle Dermatology, SC. The collection vendor may report your delinquency to a credit bureau and may file litigation in efforts to collect the total balance due. Any litigation fees will be applied to the collection balance.

Returned Checks: Pinnacle Dermatology, SC will charge a $35 fee for any returned checks.

Missed Appointments: If you are unable to keep your appointment please notify our office at least 24 hours in advance. Failure to provide 24-hour notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. The no-show fee is $50 for a Monday-Friday regular medical visit and $100 for Saturday appointments. The no-show fee is $99 for a cosmetic consultation and $250 for a cosmetic procedure. No-show charges are not billable to your insurance.

I have read and understand the Financial Policy and agree to its terms.

Patient or Guardian Signature:______________________________**Date:** ____________________

Name:____**D.O.B:** ___________________________

Patient HIPAA Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Authorization in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Authorization.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Patient or Guardian Signature:_____________________________________**Date:** _____________________