SelectSkinMD
DERMATOLOGY | SKIN CANCER SPECIALISTS

1600 36th Street, Suite B
Vero Beach, FL 32960
Phone: (772) 567-1164

Ver. 10/26

Date: _____

LEGAL Name: _____ **Soc. Sec#** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____ **Marital Status:** _____

Email Address: _____

Spouse or Parent / Guardian: _____

Mailing Address: _____ **City / State:** _____ **Zip:** _____

Seasonal Address: _____ **City / State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____

Preferred Language: _____ **Race:** _____ **Ethnic Group:** _____

Employer: _____ **Employer Phone:** _____

Friend or relative <u>not living with you</u> that we may contact in case of emergency {REQUIRED):

Name: _____ **Telephone:** _____

Referring Physician: _____ **City:** _____ **State:** _____

Primary Physician: _____ **City:** _____ **State:** _____

Preferred Pharmacy

Name: _____ **Street / City:** _____

WE WILL NEED TO COPY ALL OF YOUR CURRENT INSURANCE CARDS FOR OUR RECORDS

<u>Policy Holder's Insurance Information is REQUIRED to file to Insurance</u>

Primary Insurance Company

Insurance Company Name: _____ **ID:** _____

Name: _____ **Date of Birth:** _____ **Soc. Sec #:** _____

Mailing address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Employer Phone:** _____

Secondary Insurance Company

Insurance Co Name: _____ **ID #:** _____

Name: _____ **Date of Birth:** _____ **Soc. Sec #:** _____

Mailing address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Employer Phone:** _____

PATIENT INFORMATION UPDATE REQUEST FORM

Patient Name: _____
Date of Birth: _____

1. **Current Medications**
Please list all prescription, over-the-counter, and herbal supplements you are currently taking, including the dose and frequency:

_____
_____
_____

2. **Alerts**
- **Allergic to Latex? ☐ Yes ☐ No**
- **Allergic Skin Adhesive? ☐ Yes ☐ No**
- **Allergic to Lidocaine? ☐ Yes ☐ No**
- **Artificial Heart Valve? ☐ Yes ☐ No**
- **Artificial Joints within the past two years? ☐ Yes ☐ No**
- **Premedication Prior to Procedures? ☐ Yes ☐ No**
- **Blood Thinners? ☐ Yes ☐ No**

3. **Past Medical and Skin Disease History** _____
_____
_____

4. **Review of Systems**

- **Problems with Bleeding? ☐ Yes ☐ No**
- **Problems with Healing? ☐ Yes ☐ No**
- **Problems with Scarring (Hypertrophic or Keloid)? ☐ Yes ☐ No**
- **Changing Mole? ☐ Yes ☐ No**

5. **Past Surgical History** _____
_____
_____
_____

6. **Smoking History**

- **Do you currently smoke? ☐ Yes ☐ No**
- **If yes, how many cigarettes per day?** _____
- **If you quit, when did you stop?** _____
- **Years smoked:** _____

7. **Melanoma History**
- **Have you ever been diagnosed with melanoma? ☐ Yes ☐ No If yes, date of diagnosis:** _____
- **Treatment received:** _____ **Any recurrence? ☐ Yes ☐ No**
- **Family History? ☐ Yes ☐ No**
-
-

If yes, which relative?_____

8. **Healthcare Proxy / Power of Attorney (POA)**
- **Do you have a healthcare proxy or medical POA? ☐ Yes ☐ No**
- **Name of proxy/agent:** _____
- **Contact phone:** _____
- **Relationship to patient:** _____

Signature: _____

Date: _____

PATIENT PRIVACY QUESTIONAIRE

HIPAA LIFETIME

ACKNOWLEDGEMENT

PRESCRIPTION MEDICATION REQUEST CONSENT

Name: _____ **Date:** _____

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health related matters.

Please list any preferred phone numbers:

Home: _____ **Cell:** _____

Work: _____ **Other:** _____

Can we leave a message at the above numbers? ___ **Yes** ___ **No**

Are there any restrictions regarding our office contacting you with medical information?

_____

_____

Would you like to authorize an individual(s) as your personal representative? This person would have the authority to schedule, confirm or change appointments only. ___ **Yes** ___ **No** ___ **N/A**
If yes, please list full names:

_____ _____

I agree that my prescription medication history may be requested from other healthcare providers or third-party pharmacy benefit payers and used for treatment purposes.

_____ _____

Patient or Personal Representative Signature **Date**

SelectSkinMD has offered me a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

_____ _____

Patient or Personal Representative Signature **Date**

FINANCIAL POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to contact our billing office with any questions regarding filing of insurance and your financial obligation to Dr. Srivastava. Please be advised that this is not an all-inclusive list.

Please initial by each paragraph below indicating that you have read and agree to each.

Initial____ **If we participate with your insurance, we are contractually obligated to collect any deductible, coinsurance and / or co-pay at the time of service.**

Initial____ **Dr. Srivastava is a participating provider for MEDICARE, CIGNA, BLUE CROSS/BLUE SHIELD (except HMO), AVMED, WellMed, and some United Healthcare contracts – patient to inquire prior to their visit. If you have insurance coverage that is not one with which we are a provider, we will file your insurance once as a courtesy, however, if they do not pay within 30 days, any balance due will be your responsibility. If you have a co-pay stated on your insurance card, we will collect that at the time of your visit.**

Initial____ **I authorize release of information concerning healthcare, advice, treatment to my insurance company(s), other physicians' offices where I am a patient, a physician's office that I am being referred to or to a surgical facility in preparation for surgery.**

Initial____ **I understand that it is my responsibility to notify the office if my medical or medication information changes.**

I, the undersigned, authorize payment of medical benefits for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I agree to be responsible for any legal fees and I or court costs incurred as a result of my failure to pay for services rendered.

Please print Patient's Name: _____ Date: _____

Patient's or Parent/Guardian signature:_____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Srivastava for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine if these benefits are payable for related services. The Medicare provider, Dr. Monika Srivastava agrees to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed:_____ Date: _____

SelectSkinMD
160036th Street, Suite B
Vero Beach, FL 32960

SIGNATURE ON FILE

Medicare Beneficiaries

LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurances.

Print Patient's Name **HIC (Medicare#)**

Patient's Signature **Date**