Integrated Dermatology & MedSpa of Groton

Patient Name: First_________________ Middle ________ Last __________________

Street Address___________________________ Town______________ Zip__________

Preferred Phone ___________________ (cell/home/work?)

Secondary Phone ______________________(cell/home/work?) SS#________________

DOB ______________ Email ____________________________ Martial Status _______

Employer_____________________________ Address (city) ___________________

(For Minor) Parent or Guardian Name ______________________ Relationship__________

Pharmacy _______________ Town _____________ Pharmacy Card ID#_____________

May we leave a message on your ans. machine and/or cell phone?	Yes	No
May we speak with or leave message with your spouse/parents? (If yes, please list names)	Yes	No

Primary Insurance Company ____

Insured Name ____________________________ Relationship to patient _____________

Insured DOB ____/____/____ Insured Employer ______________________________

ID# ___________________________ Group# __________________ SS#____________

Secondary Insurance Company____

Insured Name ____________________________ Relationship to patient _____________

Insured DOB ____/____/____ Insured Employer ______________________________

ID# ___________________________ Group# __________________ SS#____________

I understand that I am financially responsible for all charges for services provided to me including the balance remaining after payment of insurance benefits. I authorize payment for medical services rendered and release of any medical information necessary to process this claim

Signed ____ Date _______________

Integrated Dermatology

Name: ______________________ Age: ___ Last Dermatology appointment: _____________

Primary Care/Referring MD: ______________ Pharmacy:___________ Location: _________

Reason for the visit: ____

- How long have you had this skin condition: ______________________________
- Where is this skin condition located: __________________________________
- Previous treatments for this condition: ________________________________
- Describe the symptoms you are having: __________________________________
- Does anything make it better or worse: _________________________________
- Scale 1-10, how much does this skin condition affect you: _____________________
- Any recent travel: Yes / No Location:_____________________________

Please list all medication: ____

____

Allergies: ________________ Occupation: ___________ Last Menstrual Cycle: _________

Are you Pregnant: Yes / No

Past Dermatologic conditions

-Atopic Dermatitis Yes / No

-Psoriasis Yes / No

-Basal Cell Yes / No

Squamous Cell Yes / No

-Melanoma Yes / No

-Blistering Sun Burns Yes / No

Past Medical conditions

-Diabetes Yes / No

-Cancer Yes / No

-Heart Disease: Yes / No

-Joint conditions: Yes / No

-Pacemaker: Yes / No

-Have you ever smoked: Yes / No

How are you feeling today

-Fever Yes / No

-Joint Pain Yes / No

-Bleeding Yes / No

-Nausea Yes / No

-Headache Yes / No

Family Medical History

-Skin Cancer: Yes / No If yes who and what kind: ___________

-Psoriasis Yes / No

-Eczema Yes / No

Do you wear sunscreen: Yes / No

Do you have any Cosmetic Concerns? Yes / No

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: ______________________________________ Date: ______________

NO SHOW POLICY

Please be advised that a $50.00 No Show charge will be applied to your account.

Patient, legal guargian, or responsible party signature ______________________Date__________

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We file with secondary/supplemental carriers. Medicare does not cover cosmetic procedures.

HMO, PPO or other managed care patients: You will responsible for paying your annual deductible, copayment and charges for any non-covered or cosmetic procedures.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay the bill at the time of service. The office may agree to bill insurance first in the case of expensive surgical procedures. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient, legal guardian, or responsible party signature ______________________________Date: ________

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services 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.

Signature as it appears on Medicare Card ______________________________ Date: ________

If you have a supplemental policy and it is MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

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 the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card ______________________________ Date: ________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Integrated Dermatology
481 Gold Star Highway, Suite 201
Groton, CT 06320
(860)445-8020

Patient Name____

I hereby acknowledge that I have been offered a summary or full copy (my Preference) of the Integrated Dermatology Notice of Privacy Practices. I understand that I may request a copy of any amended Notice of Privacy Practices at any time.

Signed____Date________________

Printed name____Phone________________

If not signed by the patient, please indicate your relationship to the patient: ________________

____

____

For office use only:

Signed form received from____

Refused to sign:

Reason for refusal:____

Efforts to obtain: ____