DERMATOLOGY PARTNERS of the north shore, L.L.C.

Medical History Form

Date: _____

PATIENT DEMOGRAPHICS

Legal Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: ( )_____ **Work Phone:** ( )_____ **Cell Phone:** ( ) _____
OK to leave message: ☐ Yes ☐ No **OK to leave message:** ☐ Yes ☐ No **OK to leave message:** ☐ Yes ☐ No

Date of Birth:____/____/____ **Email Address:** _____

Marital Status (Please check one): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Gender: ☐ Male ☐ Female **Preferred Language:**_____

Transgender: ☐ FTM ☐ MTF **Biological Gender:** ☐ Male ☐ Female

Ethnic Group (Please check one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Please check one):
☐ White
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other Race

Employed By:_____ **Occupation:** _____

Have we ever treated any other member of your family? ☐ Yes ☐ No **Name(s):** _____

REFERRAL SOURCE

Referred By: ☐ Physician ☐ Family ☐ Friend **Name(s):** _____

RESPONSIBLE PARTY (Who is responsible for the account *IF* different than above?)

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: ( )_____ **Work Phone:** ( )_____ **Cell Phone:** ( ) _____

Date of Birth:____/____/____ **Relation to Responsible Party:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder: _____
Date of Birth of Policy Holder: _____

Relation to Policy Holder: _____

SECONDARY INSURANCE

Policy Holder:_____
Date of Birth of Policy Holder: _____

Relation to Policy Holder: _____

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Northbrook, IL 60062

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DERMATOLOGY PARTNERS of the north shore, L.L.C.

Medical History Form

Patient Name: _____ **Date:** _____

PHARMACY YOU USE

Name of Pharmacy: _____

Address: _____

Phone Number: _____

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ **None**
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH (Enlarged Prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Chronic Lung Disease)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

☐ Other: _____

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ **None**
- ☐ Appendix Removed (Appendectomy)
- ☐ Bladder Removed (Cystectomy)
- ☐ Breast Biopsy
- ☐ Lumpectomy ☐ Right ☐ Left
- ☐ Mastectomy ☐ Right ☐ Left
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon Removed (Colostomy)
- ☐ Gallbladder Removed (Cholecystectomy)
- ☐ Biological Valve Replacement
- ☐ Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Mechanical Valve Replacement
- ☐ PTCA (Angioplasty)
- ☐ Hip Replacement ☐ Right ☐ Left
- ☐ Knee Replacement ☐ Right ☐ Left
- ☐ Kidney Biopsy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries Removed: Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas Removed (Pancreatectomy)
- ☐ Prostate Removed: Prostate Biopsy
- ☐ Prostate Cancer
- ☐ TURP (Prostate Surgery)
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Basal Cell Carcinoma
- ☐ Melanoma
- ☐ Skin Biopsy
- ☐ Squamous Cell Carcinoma
- ☐ Spleen Removed (Splenectomy)
- ☐ Testicles Removed (Orchiectomy)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer

☐ Other: _____

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Medical History Form

Patient Name: _____ **Date:** _____

SKIN DISEASE HISTORY (Please check all that apply)

☐ **None**

☐ 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

☐ Other: _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Any other family history: _____

MEDICATIONS (Please enter all current medications, dosage and frequency)

May we view your online prescription history? ☐ YES ☐ NO

Medication / Dosage / Frequency	Medication / Dosage / Frequency

☐ **None**

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MEDICATION ALLERGIES (Please enter all medication allergies)

Other Allergy: _____

☐ **NO KNOWN DRUG ALLERGY**

SOCIAL HISTORY (Please check all that apply)

Cigarette Smoking:

- ☐ Current every day smoker
- ☐ Current some day smoker (tobacco)
- ☐ Current some day smoker (cigarette)
- ☐ Quit: Former Smoker
- ☐ Never Smoked
- ☐ Smoker, current status unknown
- ☐ Cigar Smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker

Alcohol Use:

- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

FAMILY MEDICAL HISTORY (Please be specific; ONLY MAJOR MEDICAL HISTORY)

- ☐ Mother _____
- ☐ Father _____
- ☐ Sister _____
- ☐ Brother _____
- ☐ Daughter _____
- ☐ Son _____

☐ **None**

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The Notice of Privacy Practice for the office of Dermatology Partners of the North Shore, LLC is available at the front desk and on our website at http://www.dpns.net. The Notice of Privacy Practices may change from time to time, and you are welcome to request a revised copy at your next visit or call our office to request a copy.

SECTION I – This document provides your acknowledgement that you have had an opportunity to read our Notice of Privacy Practices.

SECTION II – To authorize other persons to request, receive, or discuss your private health information (PHI).

SECTION III – Acknowledgement that you have read and agree to our Financial Policy.

SECTION IV – Authorize DPNS to send and receive PHI to and from your insurance company.

SECTION I – ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have had an opportunity to read the Notice of Privacy Practices for the office Dermatology Partners of the North Shore, LLC.

Print Patient Name: _____ Signed: _____ Date: _____

SECTION II – PATIENT COMMUNICATION AUTHORIZATION

Persons Authorized to Receive Information about my Healthcare

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize physicians and staff to communicate and/or leave messages for me at:

	(Circle One)	
Home	Yes	No
Work	Yes	No
Cell	Yes	No

SECTION III – FINANCIAL POLICY EFFECTIVE 11/1/09

I certify that I have been given an opportunity to read DPNS's financial policy and agree to make all payments due to Dermatology Partners of the North Shore as a result of all co-pays, co-insurances, deductibles, pre-existing conditions, cosmetic procedures, product purchases, same day cancellation, no show fee, and any other out-of-pocket expenses incurred not covered by insurance. Lab tests and physician services for Alopecia may be considered cosmetic/not medically necessary by my insurance company and I will be responsible for the bill.

Signed: _____ Relationship to Patient: _____ Date: _____

SECTION IV – INSURANCE AUTHORIZATION

INSURANCE PAYMENT RELEASE

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process an insurance claim.

Signed: _____ Relationship to Patient: _____ Date: _____

MEDICARE PATIENTS

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed: _____ Date: _____

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Dermatology Partners of the North Shore, LLC
400 Skokie Blvd, Suite 475
Northbrook, IL 60062

Patient Credit Card on File Agreement

Dermatology Partners of the North Shore has implemented a new credit card policy. We kindly request our patients' guardian/guarantor for a credit card which may be used later to pay any balance due on your account.

Co-pays, deposits, and fees for non-covered services are still due at the time of service.

At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent an electronic statement, to your patient portal, which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will charge the authorized credit card. A receipt for that charge will be sent to the e-mail on file.

If needed, please contact our billing department to set-up a monthly payment arrangement that works with your needs. We do not want to cause our patient's any undue hardship.

If you have any questions about the card-on-file payment method, please do not hesitate to let us know.

By signing below, I authorize Dermatology Partners of the North Shore to keep my signature and credit card information securely on-file in my account. I authorize Dermatology Partners of the North Shore to charge my credit card for any outstanding balances when due. These balances could be, but are not limited to copayment, deductible, co-insurance, non-covered services, or payer claim denials. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Visa	**MasterCard**	**American Express**	**Discover**
☐	☐	☐	☐

Credit Card Holder's Name: _____

Last 4 digits of Credit Card: _____

Expiration Date: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Patient/Guarantor Signature: _____ Date: _____

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Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy, and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in deductible/coinsurance/copay portions. These factors can drive offices to see more patients for shorter periods of time or in some cases to stop accepting insurance all together. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies take approximately 2-6 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. What you may owe depends on your individual policy. Once the insurance explanation of benefits is received/posted to your account an electronic statement will be generated and sent showing your portion. You will have 30 days to send an alternative form of payment if you prefer.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. Card information is securely protected by the credit card processing component of our HIPAA compliant practice management system and credit card manager. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system.

What if there is a payment discrepancy or I have other payment questions?
Please contact our billing department directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits.

Will I receive a paper bill by mail?
No. You will receive one electronic statement, generated to your patient portal, which will show what will be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, just hold onto the statement for your records and your card will be charged.