



Dermatology Center
of Canyon County

**Medicare Patient
Information**

Patient Name: _____ SSN#/DL# _____
Last First Middle

Date of Birth: _____ Sex: Female Male Marital Status: _____

Address: _____
Street Apt # City State Zip

() _____ () _____
Home Phone Alternative Phone Number

Insurance Information:

Primary Insurance Co: _____ ID# _____

Name of Policy Holder (Insured): _____ Insured Date of Birth: ___/___/___

Secondary Insurance Co: _____ ID# _____ Group # _____

Name of Policy Holder (Insured): _____ Insured Date of Birth: ___/___/___

Please Sign So We May Have Your Medicare Authorization on File:

I authorize any holder of medical or other information about me to release 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.

Date: ___/___/___ Signature: _____

Please Sign So We May Have Your Supplemental Authorization 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 to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: ___/___/___ Signature: _____

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 \$110.00 deductible and paying for the 20% copayment. We do file with secondary/supplemental carrier. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits to the physician.

May we leave medical information on your answering machine at home? YES NO

May we e-mail personal medical information to you? YES NO E-mail address: _____

Do you give our office permission to discuss medical information with family members? YES NO

If yes, whom? _____

Relationship to Patient Phone

Emergency Contact Information:

In case of emergency, whom should we notify? _____

Relationship to Patient Phone

Patient Signature _____ Date: ___/___/___



Dermatology Center of Canyon County
NEW PATIENT

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Date: _____
 Name: _____ Age: _____
 Referring MD: _____
 Primary MD: _____

Check the appropriate box if you or your family members have had any of the following conditions:

CONDITION	you	mom	dad	other	CONDITION	you	mom	dad	other	CONDITION	you	mom	dad	other
Stroke					Asthma					Thyroid disease				
Diabetes					Emphysema					Arthritis				
Artificial valve					Hepatitis					Seasonal allergies				
Artificial joint					Seizures					Eczema				
Heart Disease					Organ transplant					Psoriasis				
High blood pressure					Immune suppression					Cancer Type:				
Chest pain					HIV or AIDS					Melanoma				
Pneumonia					Kidney disease					Skin cancer				
Other Health conditions. List: _____														

Do you have any allergies to medications? No Yes _____

Are you currently pregnant? No Yes N/A Are you planning a pregnancy? No Yes N/A

Do you require antibiotics before dental work or other procedures? No Yes

Spouse's name (if applicable): _____ Number of children (if applicable): _____

Do you smoke? No Yes Amount _____ Do you drink alcohol? No Yes Amount _____

Do you have any of the following symptoms?

Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle/joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain/Difficulty urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea/vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____

Do you have a history of blistering sunburn? Yes No Do you wear sunscreen daily? Yes No

List all medications you are currently taking (include over-the-counter medications, vitamins and herbals).

Reason for today's visit: _____

OFFICE USE ONLY

