Patient Information

Patient's Full Name_____ Sex _____

Street Address_____

City, State, Zip _____

Phone (home) _____ (work/cell)_____

Employer_____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Referred by _____

**Due to Health Care Reform this information is now required for reporting purposes.*

Ethnicity _____ Race _____ Preferred Language_____

Insurance Information – Please present your insurance card

Primary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birth date _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone_____

Secondary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birth date _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone_____

I understand that regardless of my insurance status I am ultimately responsible for the balance of my account. I have read all of the information on BOTH sides of this sheet and have completed the above information. I certify this information is true and correct to the best of my knowledge. Grekin Skin Institute has permission to contact me by email. I further understand that if I consent to the photographing of skin conditions these may be used for educational, training and patient awareness purposes. Additionally, I hereby authorize the release of any protected health information necessary to process claims for medical services performed on me. I also request that payment be sent to the provider of services Dr. Steven K. Grekin, Dr. Don Collier, Dr. Wendy Lambert, Dr. Michelle K. Bruner, Dr. Michael W. Whitworth, Dr. Arathi Goldsmith, Dr. Jean M. Holland, Jan Prusinowski, PA-C, Jennifer Meitzner, NP, and Gail M. Oehmke, RN.

*** 24-hours is required for cancellations to avoid $50 collection fee ***

Signature_____ Date: _____

Updated _____ Date: _____

Updated _____ Date: _____

Grekin Skin Institute

About Financial Arrangements

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered unless we are aware you have insurance coverage for this particular visit. It is the patient/subscriber's responsibility to submit claims covered under any Master/Major medical policy, unless prior arrangements have been made with the office staff. Returned checks and balances older than 30 days may be subject to additional collection fees.

We participate with various insurance plans, accepting assignment of benefits. Please check with your insurance company to verify that the doctor you are seeing is a participating provider. Copayments, coinsurances, and deductibles remain your responsibility. It is the responsibility of the patient/subscriber to obtain any necessary referral forms or authorization numbers. If you fail to obtain these necessary forms/numbers you will be held responsible for your balance. Please be advised that our office takes, CASH, CHECKS, VISA, MONEY ORDER, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.

We are happy to process other insurance plans. You must realize however, that:

1) **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.**
2) **Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies which pay a percentage (such as 50% or 80%) of "U.C.R.". U.C.R. is defined as "Usual, Customary, and Reasonable" by most companies. This is a "schedule of fees" which bears no relationship to the current standard and cost of care in the area.**
3) **Not all services are a covered benefit on all contracts. Some insurance companies arbitrarily select certain services they will not cover.**

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Should problems arise affecting your timely payment of this account, we encourage you to contact the billing office promptly for assistance in working this out.

If you have any questions regarding the above information, please do not hesitate to ask us. We are here to assist you.

Dermatology Medical History

Patient: _____ Date: ____ /____ /____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2. _____

Are you allergic to Latex? ❑ YES ❑ NO
Are you allergic to Lidocaine? ❑ YES ❑ NO

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

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑

Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Irregular Heartbeat/Murmer	❑	❑
Blood clots	❑	❑
Pacemaker/Defibrilator	❑	❑

Other Systemic:	**YES**	**NO**
Diabetes	❑	❑
Thyroid Disease	❑	❑
Kidney	❑	❑
Bladder Infections	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Joint Pain	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ❑ YES ❑ NO If yes, _____
Has anyone in your family had skin cancer? ❑ YES ❑ NO If yes, _____
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment? _____

Social History:

Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO

Please answer the following questions:

(Women) Are you pregnant? ❑ YES ❑ NO First Day of Last Menstrual Cycle: ____ /____ /____

What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient
❑ Medical Assistant _____ Initials

_____ ____ /____ /____
Signed by Patient Date

_____ ____ /____ /____
Reviewed by Date

Patient Intake Form Meaningful Use Measures

Our practice is now using an electronic health record called DrFirst RcopiaMU. We are participating in the meaningful use program sponsored by the federal government. This is due to President Obama's Healthcare Reform. We are collecting this data to be compliant with the program in an effort to increase patient safety, improve patient care and create a complete patient record. We appreciate your assistance with providing our practice this information.

Please fill out completely

Full Name	
Date of Birth	
Gender	*Please indicate your gender (circle):* **Male** **Female**
Race	*Please indicate your race (circle):* **Other** **Black or African American** **American Indian or Alaska Native** **Native Hawaiian or Other Pacific Islander** **Asian** **White**
Ethnicity	*Please indicate your ethnicity (circle):* **Other** **Arab-American** **Hispanic/Latino** **Non-Hispanic/Latino**
Preferred Language	*Please select your preferred language (circle):* **English** **Chinese** **Arabic** **Spanish** **Japanese** **Asian/Pacific Island Language** **French** **Italian** **Other Indo-European Language** **Portuguese** **Russian** **Other (Please Specify)** _____
Smoking Status	*Please select your current smoking status (circle):* **Current every day smoker** **Current some day smoker** **Former smoker - Please list date range you smoked _____to_____** **Never smoked** **Smoker, current status unknown** **Secondhand Smoke**
Height & Weight	_____ **Feet** _____ **Inches** _____ **lbs**
Do you have any *medication* allergies? **Yes or No**	***If yes, what are you allergic to?*** _____
Are you taking any medications? **Yes or No** ***INCLUDING:*** **Supplements, vitamins or over-the-counter products**	***If yes, which medications?*** _____
Pharmacy Information	**Pharmacy Name:** _____ **Phone Number:** _____ **Cross Streets:** _____ **City:** _____

Office Use Only: _____ ***MA Initials*** **Date of Office Visit:** _____

Chart Number: _____ **Dr:** G B H W AG C L Un

Diagnosis: _____ _____