

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M or F Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_ Text Reminders: Y or N Email Reminders: Y or N Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY BILLING INFORMATION:**

**\*PLEASE LIST PERSON RESPONSIBE FOR THE BALANCE AFTER INSURANCE HAS PAID.\***

Relationship to Patient: **[ ]** Self **[ ]** Parent **[ ]** Guardian **[ ]** POA **[ ]** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION: \*PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST SO COPIES CAN BE MADE\***

**\*THIS INFORMATION IS TO BE FILLED OUT IF THE INSURANCE IS THROUGH SOMEONE OTHER THAN THE PATIENT\***

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber SSN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber SSN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHRORIZATION, FULL DISCOLURE STATEMENT, AND AGREEMENT TO PAY FOR SERVICES:**

I hereby authorize Dermatology Center of Owensboro to release any information necessary to process my insurance/Medicare claim acquired in the course of my examination or treatment; and to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of a lifetime. I claim any insurance benefits due to me for services rendered at DCO and authorize and direct my carrier to issue payment check(s) directly to DCO. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient of Representative Date



**COSMETICS:**

Are you interested in any cosmetic services that our practice has to offer?

Dr. Ben Vessels would be glad to discuss all the treatment options and services during a **FREE** 30 minute cosmetic consultation. Please circle all apply:

Dermal Fillers (Juvederm) Microdermabrasion Kybella Rejuvapen

Botox Skin Care Products Laser Treatments Latisse

**CONSENT TO RELEASE INFORMATION:**

I authorize medical providers and personnel of Dermatology Center of Owensboro to discuss and release my protected health information regarding my care and scheduled appointments, and to release financial information, to the following family members, legal representative, and/or other designee:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

I authorize Dermatology Center of Owensboro to release and/or obtain copies my protected health information from previous or current physicians, this is including Epic.

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Signature of Patient or Representative Date

**AUTHORIZATION TO LEAVE MESSAGE:**

May we leave a verbal message with whomever answers the phone? YES NO

May we leave a message on your home answering machine or cell phone? YES NO

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM:**

I have been made aware of Dermatology Center of Owensboro’s Notice of Privacy Practices posted in the office. A copy may be provided upon my request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Representative Date



**FINANCIAL POLICY:**

Thank you for choosing Dermatology Center of Owensboro for your dermatological care. Your health is our greatest priority. Of course, as with any business, we must reconcile our financial relationship as well. Patients have access to a variety of health care plans, and our financial relationship is dictated primarily by the health plans they choose. Many plans have a co-payment and/or a deductible, and it is our responsibility to collect those fees **at the time of each visit** to our office. Our contract with your insurance carrier **requires** us to make those collections. We appreciate your cooperation with our staff in this regard. If you have questions about this process, please contact your insurance company or ask to speak with our Billing Specialist.

**PAYMENT:**

Co-payments and deductibles will be collected at the time of service. If you do not have health insurance or you are receiving a non-covered service, payment is due on the date of service.

**INSURANCE:**

We file your insurance claim as a courtesy. Ultimately, expenses incurred are the responsibility of the patient. Should your insurance company deny your claim or not respond to our collection efforts, payment will be expected from the patient.

**RETURNED CHECKS:**

A fee of $35 will be assessed on any check returned or otherwise not honored by your bank. This fee is due in cash when you come to the office to retrieve the original check.

**STATEMENTS:**

After claims are filed with your insurance and the insurance company responds, a statement of your account is mailed to you. The statement reflects the amount owed to our practice or an amount we owe you (refund). If your account is not paid timely, then the outstanding balance may be given to a collection agency. Insurance and billing is performed by our office. Please direct questions about your account to our Insurance and Billing Specialist.

**NO-SHOW AND LATE ARRIVAL POLICY:**

We understand that there are times when patients must miss an appointment due to emergencies or other obligations. However, failure to call our office to cancel appointments in a 24-hour notice prevents other patients from being seen. The practice allows **3 un-notified no shows**. After the 3rd no show, patients will be charged a **$25** no show fee that must be paid prior to being seen or making any additional appointments. Appointments cancelled 24 hours in advance do not count as a no show.

Due to our high patient demand and an extended wait list, if you are more than **15 minutes** **late** for your appointment you will be asked to reschedule your appointment.

**I HAVE READ, UNDERSTAND, AND AGREE TO THESE POLICIES.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Representative Date

**PATIENT HISTORY FORM**

**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy & Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** (please circle all that apply)

Anxiety

Arthritis

Asthma

Atrial fibrillation

Bone Marrow Transplant

Organ Transplant

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Diabetes

End Stage Renal Disease

(Kidney)

GERD

Hearing Loss

Hepatitis/Liver Disease

High Blood Pressure

HIV/AIDS

High Cholesterol

Hyperthyroidism or Hypothyroidism)

Leukemia/Lymphoma

Lung Cancer

Prostate Cancer

Radiation Treatment

Seizures

Stroke

**NONE**

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY:** (please circle all that apply)

Appendix Removed

Bladder Removed

Mastectomy (R, L, or both?)

Lumpectomy (R, L, or both?)

Colectomy/colon removed:

Due to colon cancer,

Diverticulitis, or IBD?

Gallbladder Removed

Coronary Artery Bypass

Heart Valve Replacement

-mechanical or biological?

Heart Transplant

Joint Replacement (last 2 yrs)

Hip: (R, L, or both)

Knee: (R, L, or both)

Kidney Removed (R or L?)

Kidney Stone Removal

Kidney Transplant

Ovaries Removed

-Due to cancer, cyst, or endometriosis

Prostate Removed

Spleen Removed

Testicle Removed

Hysterectomy

-Due to cancer or fibroids?

**NONE**

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN DISEASE HISTORY:** (please circle all that apply)

Actinic Keratosis (pre-cancers)

Basal Cell Skin cancer

Blistering Sunburn(s)

Melanoma

Precancerous Moles

Psoriasis

Squamous Cell skin cancer

Skin cancer (unknown type)

**NONE**

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a **FAMILY** history of melanoma? YES NO If yes, which relative? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS: STRENGTH, DOSE, FREQUENCY:** (please list all medications or attach a list) **NONE**

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**ALLERGIES TO MEDICATIONS**: **NONE** (please list all allergies or attach a list)

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Seasonal allergies/Hay fever: YES NO

**Do you smoke cigarettes?** Current Smoker Former Smoker Never Smoker

**Do you use alcohol**? NONE Less than 1 drink per day 3 or more drinks per day

**FAMILY HISTORY:** (only if **first degree** relative-please indicate if Mother, Father, Sister, Brother, or child)

Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if so, what type?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coronary Disease/Heart Attack\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Melanoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psoriasis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**: Are you currently experiencing any of the following? (Please circle all that apply)

Problems with bleeding

Problems with healing

Problems with scarring (keloid, etc.)

Rash

Immunosuppression

Chest pain

Fever or chills

Unintentional weight loss

Thyroid problems

Sore throat

Blurry vision

Abdominal pain/ Bloody stool

Joint aches

Muscle weakness

Seizures

Shortness of breath

Anxiety

Depression

**NONE**

**ALERTS**: (please circle all that apply)

Allergy to Adhesive

Allergy to lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joint replacement

Blood thinners

Defibrillator

Pacemaker

Require antibiotics prior to a surgical procedure

**NONE**

Are you currently **pregnant or trying** to get pregnant? YES NO N/A