



**PATIENT INFORMATION** This section must be completed for all patients:

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I.

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

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female Social Security #: \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Other \_\_\_\_\_

Spouse Name: \_\_\_\_\_ DOB \_\_\_\_\_

Race:  White  Hispanic  African American  Asian  Other \_\_\_\_\_

Employment Status:  Full Time  Part Time  Disabled  Unemployed  Student FT/PT  Retired

Language:  English  Spanish  Other \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Emergency Phone: ( ) \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**PREFERRED PHARMACY:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Phone:** ( ) \_\_\_\_\_

If the patient is a minor, at least 16 years of age and you give consent for them to be seen without the parent or guardian present please sign below:

X \_\_\_\_\_  
Parent or Guardian Signature Print Name, Relationship Date

**RESPONSIBLE PARTY INFORMATION (if different from patient)** Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M.I.

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

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

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

Is the responsible party currently a patient in our office?  Yes  No

**INSURANCE INFO:** Do you have health insurance?  Yes  No Guarantor is the person whose NAME is on the insurance card.

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

Insurance Address: \_\_\_\_\_ Insurance Address: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Insurance Group #: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

Name of Guarantor: \_\_\_\_\_ Name of Guarantor: \_\_\_\_\_

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

**Guarantor Date of Birth:** \_\_\_\_\_ **Guarantor Date of Birth:** \_\_\_\_\_

# ABERDEEN DERMATOLOGY ASSOCIATES, LLC

## INSURANCE AND MEDICAL RECORD AUTHORIZATION

I authorize Aberdeen Dermatology Associates to furnish information to my insurance carrier, or its intermediaries, or supplemental insurance, cancer/accident insurance concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered. I authorize the release of my medical records to the referring physician and to my insurance company should it be requested.

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*Signature of Patient or Legal Guardian*

*Date*

*Relationship*

## RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of the Notice of Privacy Practices of Aberdeen Dermatology Associates. This document is available at our front desk or at [www.aberdeenderm.com](http://www.aberdeenderm.com).

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*Signature of Patient or Legal Guardian*

*Date*

*Relationship*

## FINANCIAL POLICY

**Thank you for choosing Aberdeen Dermatology Associates. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit, please contact our Billing Department as soon as possible, as we may have deadlines to resolve any discrepancies. We are providers with the following insurance companies: Wellmark Blue Cross Blue Shield, Dakotacare, Avera Health Plan, Sanford Health Plan, Medicare, South Dakota Medicaid, Tricare and The Veterans Administration.**

**Private Pay:** Payment for services provided is due and payable at the time of service.

**Policy Benefits/Non-Covered Charges:** You are responsible to know your insurance policy coverage and benefits. You are responsible for any deductible, co-payments or non-covered by your insurer. You have the right to refuse any services before they are rendered if you think they are non-covered services or non payable by insurance.

**Co-payments:** You are expected to pay the co-payment as defined by your plan at the time of service.

**Out-of-Network Insurance Plans:** You are responsible for obtaining any prior authorization for GAP exceptions or Care Availability.

**Cosmetic Services:** Cosmetic procedures are not covered by insurance. All cosmetic services are payable at the time of service.

**Referrals:** It is the patient's responsibility to ensure that referrals are provided to the practice prior to your visit. Visits may be re-scheduled due to lack of referral.

**Pathology/Lab:** You are responsible to know from whom your insurance company requires me to obtain any labs , x-rays, or any other ancillary services. Please let your doctor's medical staff know so that they may schedule these services accordingly. You will be billed separately for any ancillary services as these are separate providers from Aberdeen Dermatology Associates.

**Patient Responsibility:** We suggest that you stay in communication with your insurance company to assure that they are paying for the services we render. Often, insurance companies are more responsible when they are contacted by their policy holders, In addition, should our billing office contact your for assistance in obtaining payment from your insurance company, your prompt response to their calls would be appreciated.

**Collection Charges:** All outstanding accounts will be turned over to a collection agency after making all possible attempts to collect.

**Methods of Payment:** Our office accepts personal checks, cash, MasterCard, Visa, Discover or American Express. There is a \$40 charge to the patient for returned checks due to insufficient funds or closed accounts.

**I have read, and understand my financial obligation to Aberdeen Dermatology Associates, I agree to abide by the terms states above.**

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*Signature of Patient or Legal Guardian*

*Date*

*Relationship*

# ABERDEEN DERMATOLOGY ASSOCIATES MEDICAL HISTORY

Patient \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

## PAST MEDICAL HISTORY (please check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> Depression              | <input type="checkbox"/> Hypothyroidism      |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Leukemia            |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> End State Renal Disease | <input type="checkbox"/> Lung Cancer         |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Lymphoma            |
| <input type="checkbox"/> Bone Marrow Transplant                    | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Prostate Cancer     |
| <input type="checkbox"/> BPH                                       | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer                             | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Colon Cancer                              | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> COPD                                      | <input type="checkbox"/> Hypercholesterolemia    | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Coronary Artery Disease                   | <input type="checkbox"/> Hyperthyroidism         | <input type="checkbox"/> None                |

## SURGICAL HISTORY

List any surgical procedures you've had in the last 6 months: \_\_\_\_\_

## SKIN DISEASE HISTORY (please check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acne                 | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Precancerous Moles        |
| <input type="checkbox"/> Actinic Keratoses    | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hay Fever/Allergies    | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Melanoma               | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Blistering Sunburns  | <input type="checkbox"/> Poison Ivy             | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Dry Skin             |   |  |

Do you wear Sunscreen?  Yes  No  
If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?  Yes  No

Family History of Melanoma  Yes  No  
Which Member? \_\_\_\_\_

## CURRENT MEDICATIONS

(Names including OTC, herbal & vitamins)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

NO MEDICATIONS

## DRUG ALLERGIES

(Names, reactions, ie. rash, hives, nausea, etc.)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

NO KNOWN DRUG ALLERGIES

- Never Smoked  
 Quit (Former Smoker)  
 Current Smoker

Alcohol Use:  
 None  Less than one drink per day  
 1-2/day  3+/day

I feel safe in my home?  Yes  No

## REVIEW OF SYSTEMS (please check all that apply)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Changing Mole          | <input type="checkbox"/> Hay fever        | <input type="checkbox"/> Depression    | <input type="checkbox"/> Night sweats              |
| <input type="checkbox"/> Rash                   | <input type="checkbox"/> Fever or chills  | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Unintentional weight loss |
| <input type="checkbox"/> Immunosuppression      | <input type="checkbox"/> Cough            | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Urinary tract infections  |
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Joint aches      | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Diabetic                  |
| <input type="checkbox"/> Problems with healing  | <input type="checkbox"/> Muscle weakness  | <input type="checkbox"/> Sore throat   | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Problems with scarring | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Blurry vision |  |

## ALERTS (please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Pacemaker                                  | <input type="checkbox"/> Allergy to lidocaine              |
| <input type="checkbox"/> Defibrillator                              | <input type="checkbox"/> Rapid heart with epinephrine      |
| <input type="checkbox"/> Artificial joints within the past 2 years  | <input type="checkbox"/> Premedication prior to procedures |
| <input type="checkbox"/> Heart murmur and/or artificial heart valve | <input type="checkbox"/> Yeast infections with antibiotics |
| <input type="checkbox"/> Pregnancy or planning a pregnancy          | <input type="checkbox"/> GI upset with antibiotics         |
| <input type="checkbox"/> Allergy to adhesive                        | <input type="checkbox"/> Blood thinners                    |
| <input type="checkbox"/> Allergy to topical antibiotic ointments    | <input type="checkbox"/> None                              |

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

(OVER)

# ABERDEEN DERMATOLOGY ASSOCIATES, LLC

## **CONSENT FOR THE GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES**

1. I authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional kenalog (cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by the provider(s) at Aberdeen Dermatology Associates.
2. I consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility or its designates herein, of any tissue or parts which may be removed.
3. I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in bleeding, or a permanent scar, or in discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.
4. I understand that all specimens removed are sent for dermatopathologic analysis and that the charges or dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of the charges.
5. I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses may be deemed necessary by the provider(s) to prevent the risk that these lesions evolve into Squamous Cell Carcinomas.
6. I understand that the destruction by liquid nitrogen of warts or molluscum may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they should be treated. Should the provider(s) recommend destruction of these lesion by liquid nitrogen, I consent based on that advice. I am aware that these lesions may require more than a single treatment.
7. I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by the provider(s).
8. I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis), or an allergic reaction to anesthetic or bandages.
9. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures. Further surgery or treatments may be required.
10. I understand Aberdeen Dermatology Associates will take photographs of me for my medical records. I understand the photographs may include appropriate portions of the body to demonstrate procedures and that every effort will be made to protect my identity in those materials.
11. In the event that Aberdeen Dermatology Associates needs to contact you regarding an appointment, lab results, medication, or any other reason, it is permissible to contact me at:

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Yes  No Aberdeen Dermatology Associates can speak with other authorized entities listed below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**I CERTIFY THAT I HAVE READ, AND FULLY UNDERSTOOD THE ABOVE CONSENT.**

Signature of Patient or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_