YARDLEY DERMATOLOGY ASSOCIATES

PATIENT INFORMATION FORM

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Initial: ___

DOB: ______________________ Sex: ☐ M ☐ F SS#: ______________________

Address: ______________________ City/State: ______________________ Zip: ___________

Employer/School: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

INSURANCE POLICY HOLDER INFORMATION

Policy Holder: ☐ Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other: ______________________

Last Name: ______________________ First Name: ______________________ Middle Initial: ___

DOB: ______________________ Sex: ☐ M ☐ F Phone #: ______________________

Address: ______________________ City/State: ______________________ Zip: ___________

Secondary Insurance Policy? ☐ Yes ☐ No

Last Name: ______________________ First Name: ______________________ Middle Initial: ___

DOB: ______________________ Sex: ☐ M ☐ F Phone #: ______________________

Address: ______________________ City/State: ______________________ Zip: ___________

PRIMARY CARE INFORMATION

Primary Care Physician (PCP): ____

Address: ______________________ City/State: ______________________ Zip: ___________

Phone #: ______________________ Did your PCP refer you? ☐ Yes ☐ No

PHARMACY INFORMATION

Pharmacy: ______________________ Phone #: ______________________

YARDLEY DERMATOLOGY ASSOCIATES

PATIENT CONTACT FORM

I would like to receive my courtesy appointment reminder via: ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Yardley Dermatology Associates has my permission to:

☐ **YES** ☐ **NO** **Contact me at home #:** ______________________________
☐ YES ☐ NO Leave a detailed voicemail message
☐ YES ☐ NO Leave a detailed message a household/family member

Household/Family member(s) name(s): ______________________________

____

☐ **YES** ☐ **NO** **Contact me by cell phone #:** ______________________________

☐ **YES** ☐ **NO** **Contact me at work #:** ______________________________
☐ YES ☐ NO Leave a detailed voicemail message
☐ YES ☐ NO Leave a detailed message with a staff member

Staff member(s) name(s): ______________________________

____

☐ **YES** ☐ **NO** **Contact me by e-mail**
E-mail: ______________________________
☐ YES ☐ NO Leave appointment reminders via e-mail in addition to a phone reminder

☐ **YES** ☐ **NO** **Discuss my medical history with anyone other than myself**
(In addition to those specified by law to carry out treatment, payment, and healthcare operations)
Name(s): ______________________________

____

Emergency Contact

Name: ______________________________

Phone #: ______________________________

______________________________ ______________________________
Signature of Patient or Legal Guardian Date

____
Printed Name of Patient

YARDLEY DERMATOLOGY ASSOCIATES

PATIENT CONSENT FORM

Patient Name (print): ____ DOB: ____________

Legal Guardian Name (print): ____

AUTHORIZATIONS

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to YARDLEY DERMATOLOGY ASSOCIATES. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa™, or Mastercard™. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered service, and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

Patient or Legal Guardian Signature: ____ Date: ______________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent YARDLEY DERMATOLOGY ASSOCIATES may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to YARDLEY DERMATOLOGY ASSOCIATES' Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. YARDLEY DERMATOLOGY ASSOCIATES reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to YARDLEY DERMATOLOGY ASSOCIATES Privacy Officer at 903 Floral Vale Blvd. Yardley, PA 19067. With my consent YARDLEY DERMATOLOGY ASSOCIATES may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others. With my consent YARDLEY DERMATOLOGY ASSOCIATES may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent YARDLEY DERMATOLOGY ASSOCIATES may e-mail my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that YARDLEY DERMATOLOGY ASSOCIATES restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to YARDLEY DERMATOLOGY ASSOCIATES' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent YARDLEY DERMATOLOGY ASSOCIATES may decline to provide treatment to me.

Patient or Legal Guardian Signature: ____ Date: ______________

MEDICARE HEALTH INSURANCE FORM

I request that payment of authorized Medicare benefits be made either to me or on my behalf to YARDLEY DERMATOLOGY ASSOCIATES for any services furnished to me by YARDLEY DERMATOLOGY ASSOCIATES. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Patient or Legal Guardian Signature: ____ Date: ______________

YARDLEY DERMATOLOGY ASSOCIATES

PATIENT PROGRESS FORM

Name: ____ Date: ______________

Occupation: ____ Age: ______________

Medication Allergies: ____

Present or Past Medical Problems: ____

____

Previous Surgical Procedures: ____

____

Medications & Supplements: ____

____

Personal History of Skin Cancer (type, location, & date): _____________________________

____

Are you currently experiencing symptoms or problems related to:

Asthma/allergies/hayfever	☐ Yes	☐ No
Fever/weight loss	☐ Yes	☐ No
Eyes ears/nose	☐ Yes	☐ No
Heart	☐ Yes	☐ No
Lungs	☐ Yes	☐ No
Hormones	☐ Yes	☐ No
Stomach/colon	☐ Yes	☐ No
Urinary system	☐ Yes	☐ No
Muscles/bones	☐ Yes	☐ No
Neurological/seizures/headaches	☐ Yes	☐ No
Emotional/mental illness	☐ Yes	☐ No

Do have a(n)/Have you had a(n)?

Artificial joint	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Bleeding condition	☐ Yes	☐ No
Hepatitis/HIV	☐ Yes	☐ No
Heart valve infection	☐ Yes	☐ No
Radiation/X-Ray treatment	☐ Yes	☐ No
Family history of melanoma	☐ Yes	☐ No

Relationship: ______________________________

____

Tobacco Use? ☐ Yes ☐ No Alcohol/Drug Use? ☐ Yes ☐ No Pregnant or planning soon? ☐ Yes ☐ No

Reason for today's visit (include location on the body, duration of problem, description of symptoms (painful, itching, bleeding, etc.), and treatments used in the past): ______________________________

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