Advanced Dermatology and Skin Cancer Center

INTAKE FORM

First Name:____________________________ **Middle Name:**___________________ **Last Name:**____________________________

Address:____________________________________ **City:**_______________________ **State:**_____________ **Zip:**______________

Date of Birth:___________________ **Social Security Number:**______________________________ **Sex:** □ Male □ Female

Marital Status: □ Married □ Single □ Widowed □ Divorced **Email Address:**____

□ **Home Phone:**____________________ □ **Cell Phone:**_________________________ □ **Work:**____________________
**Check preferred contact number above* □ *Check this box if it is OK to leave a detailed message on your voicemail*

□ *By checking this box you authorize Advanced Dermatology and Skin Cancer Center to use the above provided phone numbers and e-mail to disclose patient protected health information via voicemail message, text message, or e-mail. This will be used exclusively for the purpose of appointment reminders and rescheduling.*

□ **White Race and English Primary Language**

Race: □ Black or African American □ Hispanic or Latino □ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander □ White □ Other: __________________

Primary Language: □ English □ Spanish □ Other: __________________

Employer:____ **Occupation:**______________________________

Primary Care Provider:____

EMERGENCY CONTACT

Name:___________________________________ **Relationship:**____________________ **Phone Number:**___________________

INSURANCE

Primary Insurance Company Name:____ **Policy Holder:** □ Self □ Other:

Policy Holder Name:_________________________________DOB:______________Relationship to Patient:____________________

Social Security Number:___________________________________

Secondary Insurance Company Name:____ **Policy Holder:** □ Self □ Other:

Policy Holder Name:_________________________________DOB:______________Relationship to Patient:____________________

Social Security Number:___________________________________

If not listed above, do you have any insurance policy with BCBS (prescription card, supplement plan, self-pay not submitting to insurance, etc.)? □ Yes □ No *If answered yes, please explain:____

PERSON RESPONSIBLE FOR PAYMENT (Required for patients under 18 years old)

□ Self □ Other - Name: ____ Date of Birth:______________

Address:____ Phone:________________ Relationship:___________________

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to Advanced Dermatology and Skin Cancer Center & authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

All biopsy specimens are processed and submitted for histopathologic examination. You will be billed separately, at a later date, for these services by Advanced Dermatology and Skin Cancer Center P.A., University Physicians Inc. in Colorado, or another dermatopathologist.

____ _______________________________________

Signature of Patient/Personal Representative **Date**

____

Relationship to Patient

Advanced Dermatology and Skin Cancer Center
2735 Pembrook Place
Manhattan, KS 66502
PHONE (785) 537-4990 | FAX (785) 537-1938

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

______*By initialing, I understand I am entitled to receive a copy of the Advanced Dermatology and Skin Cancer Center's Notice of Privacy Practices with the effective date of December 06, 2019 and that said policy is available at my request.*

FAMILY AND OTHER INDIVIDUALS INVOLVED IN YOUR CARE

I authorize Advanced Dermatology and Skin Cancer Center to verbally release all (unless otherwise specified) my medical, financial and appointment information to the following individuals:

Name of Individual	Relationship	Phone Number
		□Home □Cell
		□Home □Cell
		□Home □Cell
		□Home □Cell
		□Home □Cell
		□Home □Cell

☐ Include Emergency Contact(s) listed on Intake Form

Signature of Patient/Personal Representative ____________________ Date ____________________

Relationship to Patient ____________________ Name of Patient ____________________

Advanced Dermatology and Skin Cancer Center
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Manhattan, KS 66502
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FINANCIAL POLICY

Patients are responsible for paying co-pays and/or any previous balances at check in. Acceptable forms of payment include cash, check, Visa, Mastercard, American Express and Discover. A $30 fee will be applied for all returned payments.

Insurance: We accept Medicare, Blue Cross and Blue Shield of Kansas, United Health Care, the Veterans Administration, Tricare and most other major insurances. Please contact your insurance company to verify coverage with our practice.

Proof of Insurance: Patients will be responsible for providing a physical copy of their insurance at check in. Patients without proof of insurance will be considered self-pay. Please notify our office of any changes in your insurance and provide updated copies of insurance cards.

Insurance Referrals: Referrals required by the patient's insurance are the patient's responsibility. If a claim is denied for lack of a referral, the patient will be responsible for the remaining balance on the account.

Self-Pay: Patients who are uninsured are considered self-pay. You will be asked to pay for your services in full at the time of your visit.

Children of Divorced Parents: The parent accompanying a child for care is responsible for providing accurate insurance information and/or payment. Statements will be sent to the primary address where the child resides.

Past Due Accounts: Accounts will be considered past due if not paid within 30 days of the statement date. If payment in full is not possible, the patient will need to contact our Business Office to make payment arrangements. Necessary steps will be taken to collect outstanding debt, including turning accounts over to a collection agency who may report to a credit bureau. The fact that you have received treatment at Advanced Dermatology will become a matter of public record if your account is submitted to a collection agency.

Cosmetic Services: **Removal of benign lesions without a medical indication such as: itching, painful, growing, bleeding, draining, being traumatized by clothing or jewelry, etc. is deemed cosmetic and is not covered by insurance.** Typically an office visit will be billed to insurance for the evaluation of these lesions. Cosmetic removal fees are separate from any visit to: evaluate, diagnose and assess if any medical indication exists to treat a lesion at the same visit. **We will not knowingly bill insurance in the hope that it may be covered.** Charges for cosmetic services must be paid in full at the time of service. Cosmetic product purchase sales are final and cannot be returned for credit or refund. Defective cosmetic product may be exchanged for the same product if the unused portion is returned to the office within 1 week of purchase. Payment and pre-payments for cosmetic procedures are non-refundable.

______________________________ Patient Signature

________________ Date

Advanced Dermatology and Skin Cancer Center

Medical History Form

Name: ______________________ Date of Birth: ______________

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End State Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Thyroid
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

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Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Bowel Resection
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Stent
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Spleen (Splenectomy)
- ☐ Uterus (Hysterectomy)
- ☐ NONE
- ☐ Other

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Advanced Dermatology and Skin Cancer Center

Medications

List all current medications:

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Allergies

List all allergies and reactions if known:

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Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoked
- ☐ Unknown if ever smoked

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Biopsy
- ☐ Dysplastic Nevus
- ☐ Eczema
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Skin Cancer
- ☐ NONE
- ☐ Other

____

____

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Do you wear sunscreen?

- ☐ Yes
- ☐ No

If yes, what SPF? ________

Do you have a family history of Melanoma?

- ☐ Yes
- ☐ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son