PATIENT INFORMATION

Name:_____ Date:_____ Sex:_____

I prefer to be called:_____ DOB:_____ Age:_____

Address:_____ Marital Status:_____

City:_____ SSN:_____

State:_____Zip:_____ Pharmacy Name:_____

Cell Phone:_____ Pharmacy Address:_____

Home Phone:_____ Primary Care Provider:_____

Work Phone_____ Employer:_____

I prefer to be reached by phone at (circle) Spouse Name:_____

Cell Home Work Any Spouse Employer:_____

Nearest Relative:_____

INSURANCE INFORMATION

Primary	Secondary
Ins. Company:_____	Ins. Company:_____
Insured's Name:_____	Insured's Name:_____
SS#:_____	SS#:_____
Insured's Date of Birth:_____	Insured's Date of Birth:_____
Policy #:_____	Policy #:_____
Group #:_____	Group #:_____
Phone #:_____	Phone #:_____

If you have a third insurance policy, please notify the receptionist.

Were you referred to us by another physician? _____Yes _____No

If yes, please write the full name and address if known:_____

_____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Abbott Dermatology P.C./The Skin Cancer Treatment Center all surgical and/or medical benefits, otherwise payable to me for services not to exceed our charges. Any unpaid deductible and/or estimated co-pays are due and payable the day of evaluation or surgery. I understand that charges not payable by insurance are my responsibility and all charges are due in full within 60 (sixty) days from the date of service regardless of any insurance pending.

I also authorize Abbott Dermatology, P.C./The Skin Cancer Treatment Center to release information acquired in the course of examination or treatment to my insurance company, peer review, or hospital if transferred for follow-up care.

**Photostat of the above is considered as valid as the original.

Signed:_____ Date:_____

MEDICAL INFORMATION

Please check any of the following you may have:

_____ High blood pressure	_____ Stomach or intestinal problems
_____ Seizures or fainting	_____ Asthma or lung disease
_____ Thyroid disorder	_____ Diabetes
_____ Blood disorders/abnormal bleeding	_____ Reaction to local anesthesia
_____ Heart disease	_____ Other serious illness
_____ Liver or gallbladder disease	_____ Women: Are you pregnant?

Have you ever been tested for the HIV virus?	_____ Yes	_____ No
If tested, were your results	_____ Positive	_____ Negative
Have you ever been tested for hepatitis?	_____ Yes	_____ No
If tested, were your results	_____ Positive	_____ Negative
If medically necessary, would you consent for lab tests?	_____ Yes	_____ No

Your results are confidential, and every effort will be made to protect your privacy. The results will be made available only to those health care workers directly responsible for your care. In Oklahoma, the law states that, if the test is positive, it must be reported to the Oklahoma State Department of Health. The test results will be available in 5 to 7 days and may be discussed with your physician. None of this information will be released except to the above named authority without your written consent.

Are you allergic or sensitive to any medication or anesthetic: _____Yes _____No
Please list or provide us with a list:

_____ _____ _____

_____ _____ _____

Are you taking any medicines? _____ Yes _____ No

Please list or provide us with a list:

_____ _____ _____

_____ _____ _____

It is permissible for Abbott Dermatology to release medical and/or appointment information to:

Spouse___Yes ___No Or other person:_____ Relationship:_____

Patient's signature:_____ Date:_____

Insured or Guardian's signature:_____ Date: _____

THE FOLLOWING QUESTIONS ARE REQUIRED
BY MEDICARE AND INSURANCE COMPANIES
Please circle:

1. Do you take a Flu Shot? Yes No Never
   About when was your last Flu Shot Month: _____ Year: _____

2. Have you ever had the Pneumonia Vaccination? Yes No

3. Have you ever had the Zoster (shingles) Vaccination? Yes No

4. Do you have a Care Plan or Advanced Directive? (This is a signed document naming someone who can legally make medical decisions for you if for some reason you are unable to make them yourself.) Yes No No, but plan to get one

5. Have you ever smoked cigarettes or used other tobacco products?
   Yes No If answered yes, please answer next question.

6. Have you smoked/used any in the past 30 days? Yes No

7. If answered yes to the above, please know that tobacco cessation assistance is available at our reception desk upon request.

HIPAA PATIENT CONSENT FORM
Notice of Privacy Practices Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This Notice contains a Patient Rights section describing your rights under the law (HIPAA: Health Insurance Portability and Accountability Act of 1996). You have the right to review our Notice before signing this Consent, and a copy is available to you.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for Treatment, Payment, and Healthcare Operations.

I am a patient/legal guardian of a patient of Abbott Dermatology/The Skin Cancer Treatment Center. I hereby acknowledge availability of Abbott Dermatology's Notice of Privacy Practices.

Name (please print):_____

Signature:_____ Date: _____

OR

I am a parent/ legal guardian of (please circle) _____ patient

Name: (Please Print):_____

Signature: _____ Date: _____