Mid-Kansas Dermatology Clinic, P.A.

PLEASE COMPLETE ALL INFORMATION FULLY (please print)

PATIENT NAME

Last ______________________ First ______________________ Middle Initial ________

ADDRESS ____
Street City State/Zip Code Home Phone

Occupation ____________________ Employer ____________________ Work Phone ________________

Date of Birth ______________ Age _____ Sex _____ Ethnicity: ______________ Cell Phone ________________

S.S. # ____________________ Nickname ____________________ E-mail ____________________

Minor _____ Single _____ Married _____ Widow _____

Spouse's Name ____________________ Employer ____________________ Work Phone ________________

IF PATIENT IS A MINOR OR DEPENDENT

Responsible Party: Last ______________________ First ______________________ Initial _______

Relationship to Patient:______________________ SSN:________________ Home Phone: ________________

ADDRESS ____
Street City State/Zip Code

Occupation ____________________Employer ____________________ Work Phone ____________________

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

_____ If I choose not to accompany my minor child or dependent to his/her follow-up appointments, I authorize Dr. Passman or his appointee to perform the treatments and/or procedures necessary to deliver appropriate healthcare. I understand this will include evaluation and management for the presenting problem. I understand it may also include prescription of medication, application of Liquid Nitrogen, as well as other minor acne and wart treatment procedures.

_____ Either I or one of the persons listed below will accompany my minor child or dependent to his/her follow-up appointments. I understand that if either I or one of the persons listed below do not accompany him/her, he/she will not be seen.

______________________________ ______________________________
Name/Relationship Name/Relationship

______________________________ ______________________________
Name/Relationship Name/Relationship

INSURANCE AUTHORIZATION AND PAYMENT POLICY

Primary Insurance ______________________ Secondary Insurance ______________________

Policy Holder ______________________ Policy Holder ______________________

ID # ______________ D.O.B. ____________ ID # ______________ D.O.B. ____________

Relationship to Patient ______________________ Relationship to Patient ______________________

AUTHORIZATOIN TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to the Mid-Kansas Dermatology Clinic, PA and/or the assigned physicians for the surgical and/or medical benefits, if any, otherwise payable to me, for services as described but not to exceed my indebtedness to said physician and/or surgeon for those services. I understand that I am financially responsible for charges not covered by my insurance AND if I do not have insurance, I am financially responsible for all charges.
INSURANCE INFORMATION AND RELEASE OF INFORMATION: I hereby authorize Mid-Kansas Dermatology Clinic, PA and/or the assigned physician to release any information acquired in the course of my examination or treatment to my referring doctor and to other medical providers for continuation of my care and/or to my insurance company.

Authorized Signature:______________________________________ **Date:** ____________________

Printed Name:________________________________**Relationship to Patient:**____________________

PATIENT NAME ______________________________ **AGE** __________ **APPOINTMENT TIME** __________

Referring Doctor ______________________________ City ______________ Phone ____________

Primary Care Doctor ______________________________ City ______________________ Phone ______________

WHAT IS/ARE YOUR PROBLEMS (rash, growths, warts, acne, eczema, etc) AND WHEN DID YOU FIRST NOTICE IT?

Main Problem ______________ First Noticed __________ Other Problem ______________ First Noticed __________

Other Problem ______________ First Noticed __________ Other Problem ______________ First Noticed __________

ARE YOU ALLERGIC TO ANY MEDICINES? (PENICILLIN, ASPIRIN, ETC) YES NO

IF YES, PLEASE LIST ____

FOR WOMEN: ARE YOU PREGNANT? YES NO

IF YES, ESTIMATED DUE DATE ____________________________________

PLEASE LIST YOUR PRESENT MEDICAL ILLNESSES: 1. ____

2. ____ 3. ____

4. ____ 5. ____

PLEASE LIST ALL PILLS, MEDICINES, OR TABLETS YOU ARE TAKING (PRESCRIPTION AND NON-PRESCRIPTION):

1. ____ 6. ____

2. ____ 7. ____

3. ____ 8. ____

4. ____ 9. ____

5. ____ 10. ____

PREFERRED PHARMACY:____

Pharmacy name **Address** **City**

Medicare Patients Only

YES **NO**

1. Is the patient a Veteran? _____ _____
   a. Did the VA refer the patient here for treatment? _____ _____
   b. Does the patient have a VA "fee basis ID Card? _____ _____
2. Does the patient have a Federal Black Lung Card? _____ _____
3. Is this medical condition due to an accident of any kind? _____ _____
   If yes, was it: Work Related ☐ Auto ☐ Injured in own home ☐ Other ☐
4. Is the patient covered by a health insurance plan through their own current employment or that of a family member? _____ _____
   (Not retiree coverage)

(Information obtained in questions 5 through 7 should be used when coding your claim for Medicare.)

5. Is the patient employed? _____ _____
   If "no": Did the patient retire in the last two years? _____ _____
   If "yes", give date of retirement: ___________________
6. Is the spouse employed? _____ _____
   If "no": Did the spouse retire in the last two years? _____ _____
   If "yes", give date of retirement: ___________________
7. Please circle the reason patient is Medicare eligible:
   Age 65 or Over Disabled End Stage Renal Disease (ESRD)
   ESRD Effective Dates: (The month kidney dialysis began)
   Part A __________ Part B __________