SENTER DERMATOLOGY

JANINE D. MILLER, MD – PATIENT DATA SHEET – PLEASE PRINT

*** PLEASE NOTE*** IF THIS FORM IS NOT FILLED OUT COMPLETELY, WILL NOT BE ABLE TO SUBMIT TO YOUR INSURANCE.

TODAY'S DATE: ______/______/________ **PATIENT DATE OF BIRTH:** ______/_____/________

PATIENT NAME: ________________________________ ________ ______________________________________
FIRST M.I. LAST

GENDER: MALE FEMALE **MARITAL STATUS:** D M S W

MAILING ADDRESS: ____________________________________ ____________________ _______ ______________
STREET CITY STATE ZIP CODE

HOME # _________________________ **WORK #**_________________________**CELL #**_________________________

CAN WE LEAVE A MESSAGE WITH TEST RESULTS AT ANY OF THE NUMBERS YOU PROVIDED? YES NO

SSN# _________________*REQUIRED FOR INSURANCE SUBMISSION* **EMAIL ADDRESS** _____________________________

OCCUPATION ______________________________**EMPLOYER**____

EMERGENCY CONTACT & RELATION TO PATIENT____________________________**PHONE #**___________________

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ___________________________**CONTACT #**______________________

MAILING ADDRESS _________________________________ _______________________ _______ ______________
STREET CITY STATE ZIP CODE

PLEASE LIST THE NAME(S) AND PHONE NUMBER(S) OF ALL THOSE THAT YOU GIVE US PERMISSION TO SPEAK TO REGARDING YOUR CARE HERE ____

____

ALLERGIES ____

CURRENT MEDICATIONS/SUPPLEMENTS ____

____

WHO IS YOUR PRIMARY CARE PHYSICIAN? ______________________________**PHONE #**_____________________

WHAT IS YOUR PREFERRED PHARMACY? ________________________ **LOCATION**___________________________

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY

ALLERGY/IMMUNO.	CARDIO-VASCULAR	SKIN	GE/GU	EYES/NOSE/EARS	PULMONARY
Food Allergy Hay Fever Lupus Rheumatoid Arthritis Scleroderma Vasculitis	High Cholesterol High Triglycerides Hypertension Heart Attack Blood Clots/DVT	Acne Eczema Herpes Keloids Melanoma Skin Cancers Warts Ulcers Cold Sores	Hemorrhoids Hiatal Hernia Hepatitis Stomach Ulcer Renal failure/dialysis Kidney Stones	Cataracts Glaucoma Deafness Sinus issues	Asthma Emphysema Tuberculosis
PSYCHIATRIC	**MUSCULO-SKEL**	**ENDOCRINE**	**BLOOD**	**NEUROLOGIC**	**OTHER**
Anxiety Depression Dementia	Arthritis Injury	Diabetes Hypothyroid Hyperthyroid	Anemia Transfusions	Stroke Dementia	____________ ____________ ____________ ____________ ____________ ____________

SYSTEMS REVIEW: CHECK ALL THAT APPLY

GENERAL	CARDIO-VASCULAR	ENT	GU	ALLERGY/IMMUNO.	PSYCHIATRIC
Appetite change Chills Dizziness Excess thirst Fatigue Fever Night Sweats Nausea or Vomiting Weight Change	Chest pain/tightness Heart murmur Legs swelling Palpitations	Bleeding gums Dry mouth Mouth ulcers Sinus Drainage Hard of hearing Ringing in ears	Blood in urine Discharge Painful urination	Watery eyes Sneezing	Memory problems Panic attacks Suicidal thoughts Suicide attempt Anxiety Depression Dementia
PULMONARY	**EYES**	**GI**	**ENDOCRINE**	**MUSCULO-SKEL**	**NEUROLOGIC**
Shortness of breath Wheezing	Dry eyes Light sensitivity Yellowing of eyes	Black/bloody stools Constipation Diarrhea Heartburn Stomach pain Trouble swallowing	Abnormal hair growth Flushing Menstrual problem	Back pain Joint pains Joint swelling Leg cramps	Blackouts Headaches Numbness
HEMATOLOGIC	**SKIN**	**OTHERS**			
Bleeding tendencies Easy bruising Swollen lymph node(s) Anemia	Blisters Itching Lesions/growths Nail changes Pigment loss Sun sensitivity Changing moles	X-ray therapy Chemotherapy			

Blood borne illness or sexually transmitted disease? (Check all that apply)	Surgical History (Check all that apply)	Social History
HIV/AIDS Hepatitis Herpes: Genital or Oral Other:- ___________________________	Do you need antibiotics before procedures? Yes No Pacemaker/Defibrillator CABG (Bypass) Heart valve repair or replaced: Left/Right Knee replacement: Left/Right Hip replacement Appendectomy Hysterectomy Other	Smoke: #/packs/day ___________ Drink alcohol: drinks/day________ Recreational Drugs:______________ ___________________________________ ______________________________________ ****FEMALES ONLY**** Are you pregnant? yes no Trying to conceive? yes no Breastfeeding? yes no On hormonal replacement therapy? yes no

FAMILY HISTORY: CHECK ALL THAT APPLY (RELATION EXAMPLE: Mother, Father, Grandmother/Father)

Diabetes Relation:	Basal Cell Skin Cancer Relation:
High Cholesterol Relation:	Squamous Cell Cancer Relation:
Cancer Relation:	Melanoma Relation:
Asthma Relation:	Lupus Relation:
Eczema Relation:	Hypertension Relation:
Arthritis Relation:	Heart Disease Relation:

For our office to provide the best medical care for our patients, we ask that you acknowledge and adhere to the office policies listed below.
******PLEASE INITIAL EVERY LINE TO ACKNOWLEDGE EACH STATEMENT******

PATIENT RESPONSIBILITIES

________ If more than three appointments are missed, or if you fail to contact our office in a timely fashion to cancel an appointment, the provider may decide to discontinue seeing you at this office.
________ It is the responsibility of the patient to respond to mailed or phone requests for follow up. Failure to respond in a timely manner to mailed or phone messages regarding your follow up may result in your discharge from this practice.

BILLING POLICIES

It is the responsibility of the patient to:
________ Provide accurate and complete insurance information.
________ Contact the insurance company if a claim is thirty days or more past due.
________ Pay all outstanding balances after sixty days, regardless of whether or not the insurance has made a determination on the claim.
_________ Promptly pay any balance remaining after the insurance finalizes the claim.
_________ Promptly respond to any questionnaires or updates sent out by the insurance company regarding coverage so as not to delay claim payment. If the patient fails to supply an insurance company with requested information, the account will be turned over to a collection agency immediately.

BILLING INFORMATION

_________ We are not accepting new patients on Medicare or Medicaid, and are not an authorized Tricare provider, nor do we participate in Workman's Compensation claims. We ask for payment at the time of your visit. We accept cash, check, MasterCard or Visa.
_________ Senter Dermatology is a preferred provider with Blue Cross, Aetna, Cigna & Multiplan. If you have questions regarding in network insurance benefit levels, please contact your insurance provider.
_________ As a courtesy to our patients, we will submit to insurance. In some cases, patients are required by their insurance company to submit themselves. If this applies to you, we will provide you with the appropriate paperwork.
_________ If there is a patient balance more than sixty days past due after a visit and the insurance company has finalized, we will charge interest on this amount.
_________ If a patient does not assist our office in settling claims, we reserve the right to stop billing insurance on any future visits, and turn the account over to an outside collection agency.

INSURANCE INFORMATION

If you do not have the following information readily available at the time of your visit you will be asked to pay your visit in full. Please present card to front desk.

Insurance Company Name: ______________________________ Insurance Phone: ________________________
Insurance Company Address: ____
Insurance Identification Number: __________________________ Insurance Group Number: _________________
Subscriber Name: ______________________________________ Subscriber Date of Birth: ____/______/_______
Subscribers Address: ____
Subscriber Social Security Number: _______________________ Subscriber Contact Number: _______________
Subscriber's Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other_________________

I attest that the above information is accurate and I understand Senter Dermatology's office policies.

X: ____________________________ __________________________________ ____/_______/________
Signature Printed Name Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

USES AND DISCLOSURES OF HEALTH INFORMATION TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS
Senter Dermatology uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:
-Sharing test results with other health care provider for confirmation of diagnosis;
-Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
-Reviewing information as part of our quality improvement program.

OTHER USES AND DISCLOSURES
Senter Dermatology may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:
-Provide you with information related to your health;
-Contacting you regarding appointments, information about treatment alternatives, or other health related services;
-Incidental uses or disclosures (e.g., listing your name on a sign in sheet, etc.);
-Compliance with all laws (including reports of suspected abuse, neglect or violence);
-Providing certain specified information to law enforcement or correctional institutions;
-Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
-Public health activities when requested by public health authority or the FDA;
-Responding to health oversight agencies;
-Responding to court or administrative tribunal orders, subpoenas, discover request or other lawful process;
-Research activities;
-When necessary to avert a serious threat to health or safety;
-Military affairs, veterans' affairs, national security, intelligence, Department of State, or presidential protective service activities;
-Providing information regarding your location, general condition or death to public or private disaster relief agencies;
-Informing a family member, other relative or close personal friend when: Information is relevant to the individual's involvement with your care;
-To assist in your health care (e.g. pick-up prescription or other documents, note follow up care instructions, etc.).

AUTHORIZATION FOR OTHER USES
Senter Dermatology will make other uses or disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice you may revoke your authorization.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH
Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:
-Request restrictions on certain uses or disclosures. However, Senter Dermatology is not obliged to agree to requested restrictions.
-Receive confidential communications of protected health information.
-Inspect and copy your protected health information with some limited exceptions.
-Amend your health information.
-Receive an accounting of disclosures of your health information.
-Obtain a copy of this notice.

SENTER DERMATOLOGY REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION
Subject to limitations outlined by law, Senter Dermatology has certain duties related to your protected health information, including:
-Senter Dermatology is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
-Senter Dermatology is required to abide by the terms of the privacy notice that is currently in effect.
-Senter Dermatology reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

Concerns
If you believe your privacy rights have been violated, you may make a complaint by contacted Senter Dermatology or the Secretary for the Department of Health and Human Services. NO individual will be retaliated against for filing a complaint.

Acknowledgement
I acknowledge that I received a copy of this notice regarding the use and disclosures of my health information.

X: ________________________________ ________________________________ ______/______/_______
Signature Printed Name Date